GROWTH IN MEDICAID SPENDING

HEARING

BEFORE THE

COMMITTEE ON THE BUDGET
HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTH CONGRESS

FIRST SESSION

HEARING HELD IN WASHINGTON, DC, APRIL 4, 1995

Serial No. 104–13

Printed for the use of the Committee on the Budget

U.S. GOVERNMENT PRINTING OFFICE

90–042cc WASHINGTON : 1995

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-047506-6

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GROWTH IN MEDICAID SPENDING

TUESDAY, APRIL 4, 1995

HOUSE OF REPRESENTATIVES,
COMMITTEE ON THE BUDGET,
Washington, DC.

The committee met, pursuant to notice, at 10:09 a.m., in room 210, Cannon House Office Building, Hon. John R. Kasich (chairman of the committee) presiding.

Members present: Representatives Kasich, Hobson, Walker, Kolbe, Shays, Herger, Allard, Miller, Smith of Michigan, Inglis, Hoke, Nussle, Largent, Myrick, Brownback, Shadegg, Radanovich, Bass, Sabo, Stenholm, Slaughter, Coyne, Mink, Orton, Pomeroy, Woolsey, Olver, Roybal-Allard, and Meek.

Mr. KOLBE. The Budget Committee will come to order.

Clearly, we have a lack of a quorum, so we will dispense with the 30-second business meeting that we had planned. At some point, we will need to get a quorum here in order to have the formality of printing the committee print of the Views and Estimates. But we will wait until we have a quorum here to do that.

The purpose of this morning's hearing is to get into—last week we talked about Medicare, listened to both people in government and from the private sector talking about Medicare. Today we are going to get into the other very major Federal program in health care, and that is Medicaid.

Few issues, I think, have been more vexing to the Congress than the subject of Federal health care programs, and it is appropriate that this committee, which sets the overall budget, should be discussing the kinds of changes that we need in order to reform and make Federal health care programs, whether they are Medicare or Medicaid, work for us and be efficient.

To lead us off in this discussion this morning, we have some very good people on our panels, but we will first hear from Dr. June O'Neill, who, as I think all of our members know, is the Director of the Congressional Budget Office.

Dr. O'Neill, we welcome you this morning for your comments and look forward to hearing from you. Dr. O'Neill.

STATEMENT OF JUNE E. O'NEILL, DIRECTOR, CONGRESSIONAL BUDGET OFFICE

Ms. O'NEILL. Mr. Chairman and members of the committee, it is my pleasure to be here today to comment on the recent growth in Medicaid expenditures and the program's projected growth under current policy.

I will summarize my prepared statement, which I would like to submit for the record.

Rapid increases in Medicaid spending and its growing share in the Federal budget present a real challenge to the Congress.

Between 1988 and 1993, Medicaid spending increased at the rate of 16 percent per year. But over the same period, total health expenditures in the Nation rose at an annual rate of only 9 percent. Medicaid expenditures are expected to continue rising faster than other health expenditures. Medicaid now accounts for about 6 percent of the Federal budget, and it is projected to climb to 8 percent by the year 2002. Modifying these trends will clearly require policy changes by both the Congress and the States.

First, some key facts about the program: Medicaid is the Nation's major health care program for low-income groups. It is jointly funded by the Federal Government and the States, and the Federal share varies from about 50 to 80 percent. But, Medicaid is administered by the States, which, though subject to Federal guidelines, retain considerable discretion over all aspects of program operation. Total Medicaid spending is expected to reach $157 billion in 1995, of which $89 billion represents the Federal share (see Figure 1 of my prepared testimony).

Traditionally, Medicaid coverage has been tied to actual or potential receipt of cash welfare benefits in the Aid to Families with Dependent Children [AFDC] or Supplemental Security Income [SSI] programs. In the last decade, however, coverage was extended to groups that do not receive cash welfare, including large numbers of children and pregnant women, as well as certain low-income Medicare beneficiaries. In 1993, more than 33 million people received Medicaid benefits.

Medicaid covers both acute medical services and long-term care. A core group of standard services is mandated by the Federal Government. States have also taken the option to cover an additional range of services, including drugs, dental services, eyeglasses, and personal-care services. The typical Medicaid beneficiary receives medical services free of charge or for a nominal copayment.

With respect to Medicaid expenditures, the largest share goes for hospital and nursing home services, which together accounted for two-thirds of the total in 1993 (see Figure 3).

Note, however, that hospital expenditures have been inflated in recent years by the inclusion of so-called DSH payments, which is short for disproportionate share payments, to hospitals. DSH payments accounted for 13 percent of total Medicaid spending in 1993.

Because of their use of nursing home services and their extensive medical care needs, elderly and disabled beneficiaries generate much higher medical expenditures than nondisabled children and younger adults. Consequently, although the elderly and disabled made up less than 30 percent of Medicaid beneficiaries in 1993, they accounted for about two-thirds of Medicaid expenditures.

Total Medicaid expenditures vary much more widely among the States than one might expect, especially given the relative size of their low-income populations. For example, in the early 1990's, about 5.5 million people in California were in families with income below the poverty level, compared with about 3 million in New

York State. But New York spent $18 billion on Medicaid whereas California spent only $14 billion.

Before 1988, the growth in Medicaid spending, although rapid, trailed behind that of private health insurance and Medicare. But during the 1988–1993 period, Medicaid expenditures soared, rising much more rapidly than private health insurance or Medicare spending.

Several factors contributed to Medicaid's dramatic growth: one, rapid increases in Medicaid enrollment; two, increases in payments for providers; and, three, financing schemes and disproportionate share payments.

The number of Medicaid beneficiaries increased by 46 percent between 1988 and 1993. This swift growth was in part driven by a series of mandatory and optional expansions in Medicaid eligibility, primarily for children and pregnant women, and these were authorized by the Congress between 1984 and 1990. The changes greatly expanded the number of Medicaid beneficiaries who do not receive cash welfare benefits.

The number of Medicaid recipients was also boosted by sizable increases in the traditional populations of cash welfare recipients in both the AFDC and the SSI programs. The expansion of disabled SSI beneficiaries put particular pressure on expenditures because it is more costly to provide medical services for these groups than it is for nondisabled children and adults.

Increases in provider payments also contributed to the rapid growth in Medicaid. Faced with burgeoning Medicaid costs and pressures to increase their reimbursement rates for providers, many States developed financing schemes to generate part of their share of Medicaid expenditures.

Those schemes, which involve voluntary donations from providers, taxes on providers, and intergovernmental transfers, drew down Federal matching dollars for what were often illusory Medicaid expenditures. Such financing mechanisms were closely associated with the rapid growth in DSH payments during the period.

The Congress took action in 1991 to limit the use of provider taxes and donations and also to place a cap on the growth of DSH payments. Further restrictions on DSH payments were enacted in the Omnibus Budget Reconciliation Act of 1993 (OBRA '93). It is still too early to assess the full impact of those provisions, but DSH payments fell in 1993 and 1994, and rapid growth in the future seems unlikely.

The future growth of Medicaid expenditures under current law will be critically affected by expansions in eligibility, changes in the mix of Medicaid beneficiaries, and the success of efforts by the States to control Medicaid spending by expanding enrollment in managed care plans. Considerable uncertainty surrounds all of those issues.

Some expansions in eligibility will occur because of the current law mandate to phase in coverage of poor children, but this is not expected to prompt rapid growth in expenditures.

Expansions in eligibility that are undertaken at the option of the States are much more difficult to predict. Several States have recently taken advantage of a provision in the Social Security Act that enables them to expand coverage to children and pregnant

women in families whose income is considerably higher than the levels nominally permitted by legislation. Moreover, several States have obtained or are seeking waivers from Medicaid regulations in order to expand insurance coverage to poor and near-poor groups.

Not all waivers that are approved, however, will actually be carried out. Nor will all the States that are considering applying in order to expand coverage actually do so, especially given the uncertainty about the future course of the Medicaid program. Furthermore, some States such as New York appear to be considering cuts in their Medicaid budgets.

The number of disabled Medicaid beneficiaries is expected to continue increasing rapidly from 1995 to 2002 and at a higher rate than other groups. The rapid increase in disabled recipients reflects the continuing outreach efforts of the Social Security Administration, a broader definition of disability than in earlier years, and the growing number of individuals reaching ages at which there is a high incidence of disability.

Contributing to the uncertain path of future increases is the fact that many States are moving quickly to enroll Medicaid recipients in managed care plans to improve access and control costs. By June 1994, about 8 million Medicaid beneficiaries, one-quarter of the total, were enrolled in managed care plans. Unfortunately, there is little empirical evidence to date that can be used to measure the effects of managed care in containing Medicaid costs.

Under current law, the Congressional Budget Office projects that the Federal share of Medicaid payments will rise from $89 billion in 1995 to $178 billion in the year 2002, reflecting an average annual rate of growth of 10.4 percent. Most of that increase represents growth in payments for medical and long-term care benefits, with DSH payments rising only slowly.

Three primary factors drive CBO's projections for the next several years: growth in the number of beneficiaries, cost increases, and residual growth. The total number of beneficiaries is expected to increase by 4 percent in 1995, slowing to a 2½-percent growth rate by the year 2002. But the number of aged and disabled recipients is expected to increase faster than the total. Accounting for that compositional change, about 40 percent of projected growth in Medicaid expenditures can be attributed to increases in the caseload.

A further 30 percent of the projected increase can be attributed to increases in prices for Medicaid services.

Finally, the projections assume that all other factors combined, excluding DSH payments, will account for about 25 percent of overall Medicaid growth; DSH payments account for 3½ percent of the total, which is the remainder.

CBO's current Medicaid projections are somewhat lower than those it made last summer. The current estimate of Medicaid spending in 1994 is about $82 billion, which is $2 billion lower than CBO had anticipated last summer. In line with the pattern for 1994, CBO has lowered its current projection for 1995 to $89 billion, which is $7 billion lower than our summer projection.

Much of the change in projected outlays resulted from this lower level of 1995 spending. CBO has also lowered the assumed rate of growth of spending by about 1 percentage point beginning in 1996.

The Medicaid projections developed by the Office of Management and Budget are lower than CBO's (see Table 4 of the prepared statement). OMB assumes that the lower-than-anticipated spending in 1994 represented a change in the program that will be sustained throughout the projection period. By contrast, CBO assumes that growth will return to more historical levels, although it will be significantly below the rapid pace of the 5-year period before 1994.

In conclusion, many of the Nation's Governors are now seeking less Federal control of the Medicaid program to enable the States to meet the needs of their particular low-income populations in a more effective manner. The States' desire for greater flexibility in addition to the rapid growth of spending make the Medicaid program ripe for change. How to limit program growth without adversely affecting the intended beneficiaries is the challenge facing the Congress and the States.

Thank you.

[The prepared statement of June O'Neill follows:]

PREPARED STATEMENT OF JUNE E. O'NEILL, DIRECTOR, CONGRESSIONAL BUDGET OFFICE

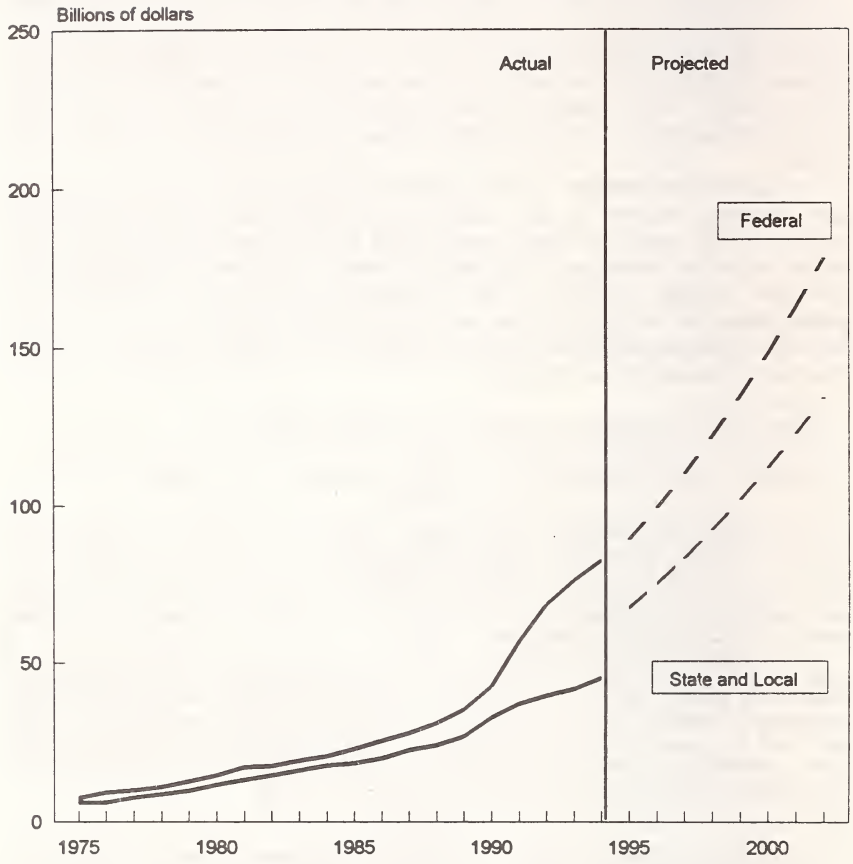
Mr. Chairman and members of the committee, it is my pleasure to be here today to share with you the analysis that the Congressional Budget Office [CBO] has conducted concerning the recent growth in Medicaid expenditures and the program's projected growth under current policy. The rapid increases in Medicaid spending and the growing prominence of the program in the Federal budget surely present a serious challenge to the Congress.

Between 1988 and 1993, Medicaid spending on average increased at the rapid rate of 16 percent a year. Yet over the same period national health expenditures were rising at an average annual rate of only 9 percent. Medicaid expenditures are expected to continue to rise faster than other health expenditures through 2002. Medicaid now accounts for about 6 percent of the Federal budget, but that percentage is projected to climb to 8 percent by 2002. Modifying those trends will clearly require policy changes by both the Congress and the States.

OVERVIEW

Medicaid is the Nation's major program providing medical and long-term care services to low-income populations. The Federal and State governments jointly fund the program. The States administer it, however, and though they are subject to Federal guidelines, they retain considerable discretion over all aspects of program operation. The Federal share of total Medicaid spending in a State varies inversely with the per capita income of the State, subject to a lower limit of 50 percent and an upper limit of 83 percent. Total Medicaid expenditures are expected to reach $157 billion in 1995, of which $89 billion—57 percent—represents the Federal share (see Figure 1).

FIGURE 1.—MEDICAID EXPENDITURES, 1975–2002



SOURCES: Health Care Financing Administration, Office of National Health Statistics, and the Congressional Budget Office.

NOTE: Historical Medicaid data are presented by calendar year. Projections of Medicaid expenditures are estimated using a federal matching percentage of 57 percent and are on a fiscal year basis.

Medicaid beneficiaries

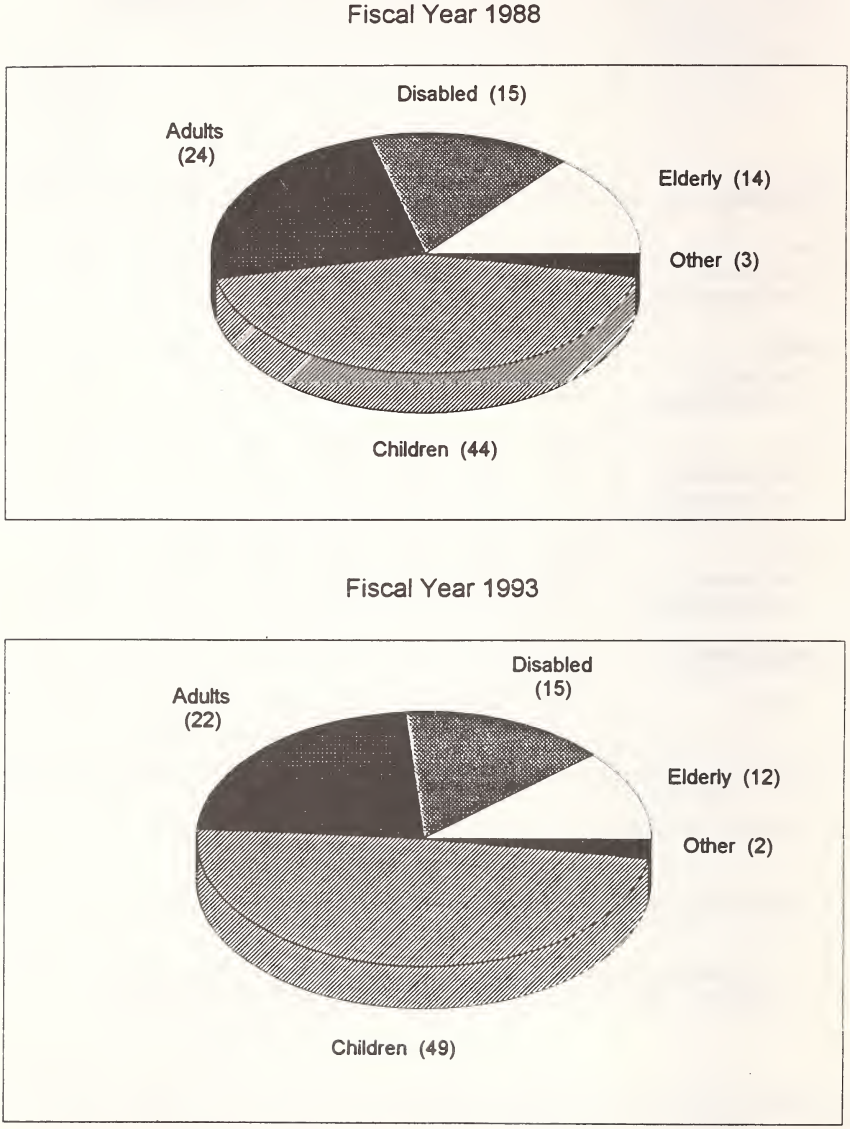
The Medicaid program has always covered recipients and potential recipients of cash welfare benefits provided through the Aid to Families with Dependent Children [AFDC] and Supplemental Security Income [SSI] programs. In addition, coverage has been extended to large numbers of poor and near-poor children and pregnant women, as well as to certain low-income Medicare beneficiaries. In 1993, over 33 million people received Medicaid benefits (see Table 1). Children under the age of 21 are by far the largest group of Medicaid beneficiaries, accounting for almost half of the total in 1993 (see Figure 2). About 12 percent of beneficiaries were elderly and 15 percent disabled. Most of the remainder were nondisabled adults.

TABLE 1. MEDICAID BENEFICIARIES, 1988-1993 (By fiscal year, in millions)

Type of Beneficiary	1988	1989	1990	1991	1992	1993	Average Annual Rate of Growth (In percent)
Elderly	3.2	3.1	3.2	3.4	3.7	3.9	4.1
Cash recipients	1.7	1.6	1.5	1.5	1.5	1.5	-1.5
Other beneficiaries	1.5	1.6	1.7	1.9	2.2	2.3	9.2
Disabled	3.5	3.6	3.7	4.1	4.5	5.0	7.5
Cash recipients	2.8	2.8	2.8	3.1	3.3	3.8	6.2
Other beneficiaries	0.7	0.8	0.9	1.0	1.1	1.3	12.2
Adults	5.5	5.7	6.0	6.8	7.0	7.5	6.4
Cash recipients	4.1	4.1	4.0	4.2	4.4	4.6	2.6
Other beneficiaries	1.4	1.6	2.0	2.6	2.6	2.9	15.0
Children	10.0	10.3	11.2	13.4	15.2	16.3	10.2
Cash recipients	8.1	7.9	8.1	8.6	9.5	9.6	3.6
Other beneficiaries	2.0	2.4	3.1	4.9	5.7	6.6	27.6
Other/Unknown	0.7	0.8	1.1	0.7	0.7	0.8	1.1
Total	22.9	23.5	25.3	28.3	31.2	33.4	7.9

SOURCE: Congressional Budget Office estimates based on data from the Health Care Financing Administration, HCFA Form-2082.

FIGURE 2.—DISTRIBUTION OF MEDICAID BENEFICIARIES BY ELIGIBILITY GROUP, FISCAL YEARS 1988 AND 1993 [IN PERCENT]



SOURCE: Congressional Budget Office estimates based on data from the Health Care Financing Administration, HCFA Form-2082.

The vast majority of Medicaid recipients are poor or near-poor. In 1992, according to the Census Bureau's Current Population Survey, 61 percent of the noninstitutionalized Medicaid population had income below the poverty level; 74 percent were below 133 percent of the poverty level. However, 16 percent had income greater than 185 percent of the poverty level.

Provision of services

Medicaid covers both acute medical services and long-term care. The Federal Government requires all States to provide a core group of services, including hospital, physician, and general nursing facility services. States have the option, however, to cover an extensive range of services in addition to the mandated ones, and all of the States do so. Optional services include drugs, dental services, eyeglasses, and personal care services. For the typical Medicaid beneficiary, acute care services are provided free of charge or for a nominal copayment. However, beneficiaries often face limited access to providers, many of whom are unwilling to see Medicaid patients.

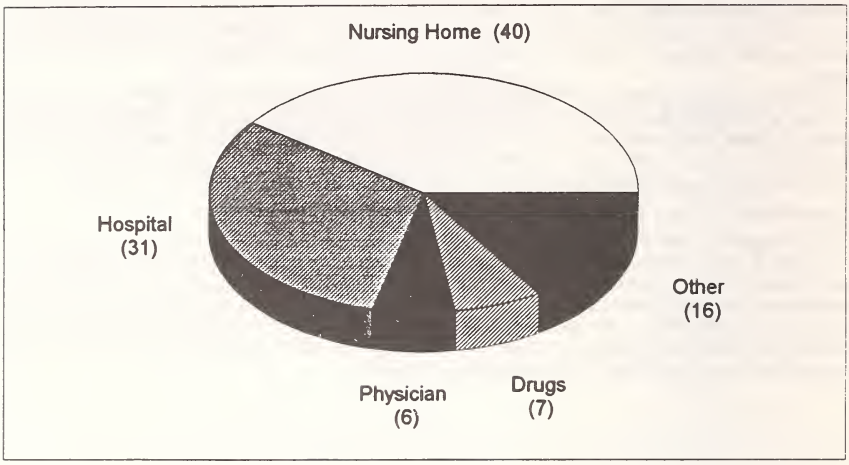
Concern about access to providers was an important factor in the decision of some States to develop managed care arrangements for providing acute care services to some of their Medicaid beneficiaries—generally nondisabled adults and children. By June 1994, about 8 million Medicaid beneficiaries—almost a quarter of the total—were enrolled in managed care plans in 42 States and the District of Columbia.

Expenditures by type of service

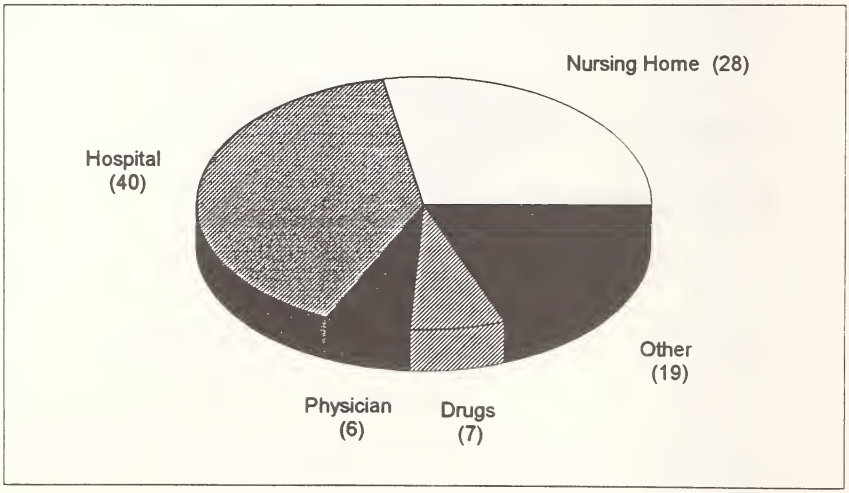
The largest share of Medicaid expenditures is for hospital and nursing home services, which accounted for two-thirds of the total in 1993 (see Figure 3). Hospital expenditures include payments to hospitals for inpatient and outpatient services received by Medicaid beneficiaries, as well as so-called disproportionate share [DSH] payments to hospitals that serve disproportionately large numbers of Medicaid and uninsured patients. Nursing homes include general nursing facilities as well as intermediate care facilities for the mentally retarded.

FIGURE 3.—DISTRIBUTION OF MEDICAID EXPENDITURES BY CATEGORY OF SERVICE, FISCAL YEARS 1988 AND 1993 [IN PERCENT]

Fiscal Year 1988



Fiscal Year 1993



SOURCE: Congressional Budget Office estimates based on data from the Health Care Financing Administration, HCFA Form-64.

NOTES: Nursing home expenditures include spending for nursing home facilities and intermediate care facilities for the mentally retarded.

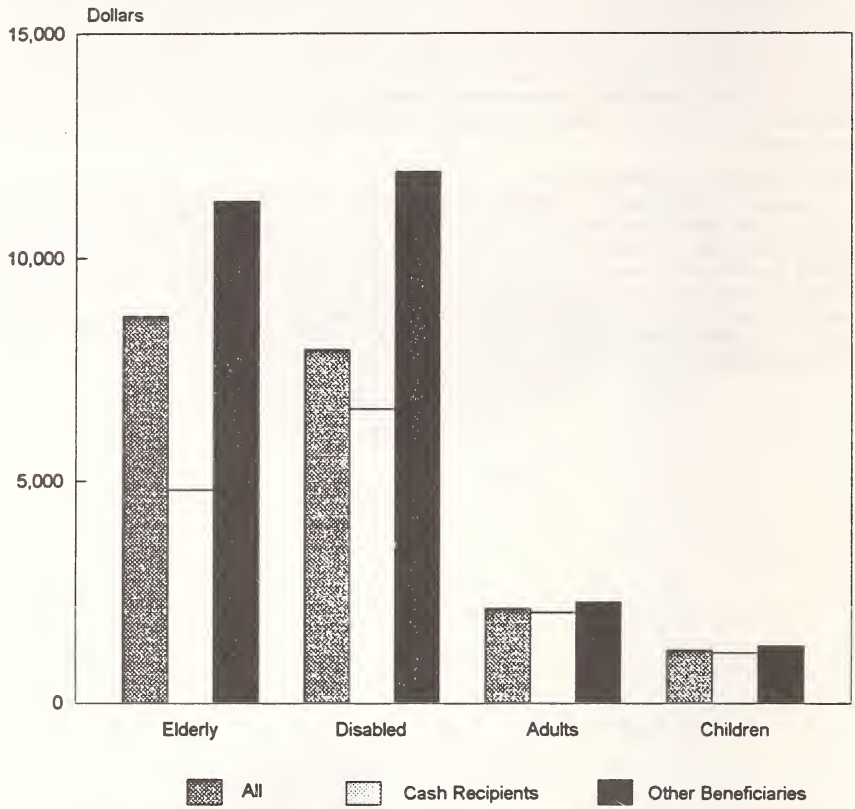
Hospital expenditures include spending for inpatient and outpatient care and disproportionate share payments.

Disproportionate share payments, as reported by the States, have grown from a negligible fraction of total spending in 1988 to 13 percent of total spending in 1993. In that year, all payments to hospitals—inpatient, outpatient, and DSH—nominally accounted for 40 percent of total spending compared with 31 percent in 1988. By contrast, spending for institutional long-term care services dropped from 40 percent in 1988 to 28 percent in 1993. As discussed later, however, part of the total reported DSH payments probably represented illusory expenditures by the States. Consequently, 40 percent is likely to be an overestimate of the actual share of spending for hospitals.

Expenditures by eligibility status

Because of their use of nursing home services and their extensive acute care needs, elderly and disabled Medicaid beneficiaries generate much higher medical expenditures than do children and other adults (see Figure 4). Some elderly and disabled beneficiaries become eligible for Medicaid because of their need for costly nursing home services, even though they have not been recipients of cash welfare benefits. As a result, although the elderly and disabled represented less than 30 percent of Medicaid beneficiaries in 1993, they accounted for about two-thirds of all Medicaid expenditures, excluding DSH payments (see Figure 5).

FIGURE 4.—MEDICAID EXPENDITURES PER BENEFICIARY, FISCAL YEAR 1993

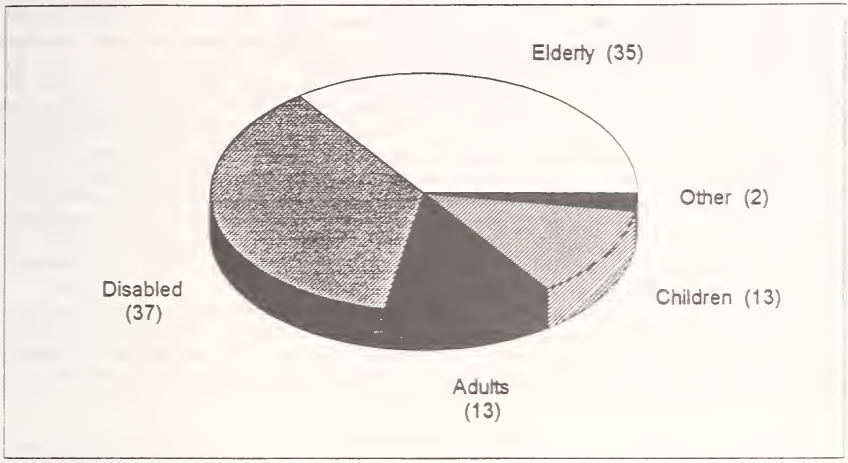


SOURCE: Congressional Budget Office estimates based on data from the Health Care Financing Administration, HCFA Form-2082 and HCFA Form-64.

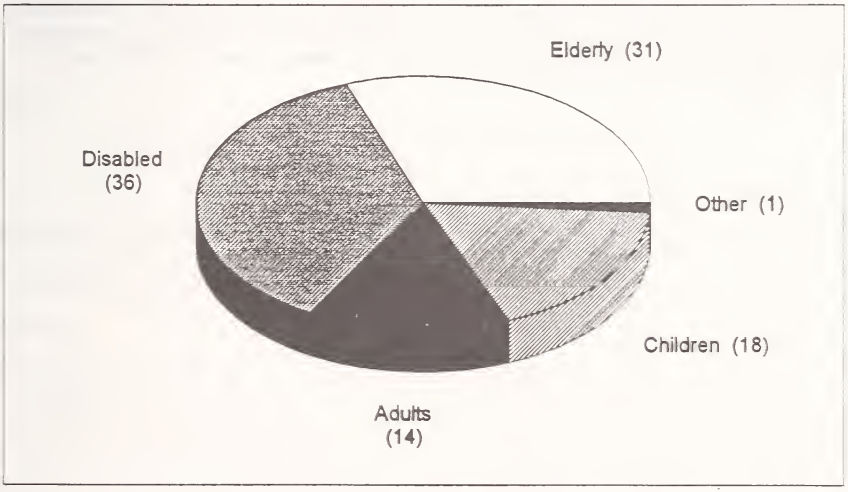
NOTE: Excludes administrative costs and disproportionate share payments.

FIGURE 5.—DISTRIBUTION OF MEDICAID EXPENDITURES BY ELIGIBILITY GROUP, FISCAL YEARS 1988 AND 1993 [IN PERCENT]

Fiscal Year 1988



Fiscal Year 1993



SOURCE: Congressional Budget Office estimates based on data from the Health Care Financing Administration, HCFA Form-2082 and HCFA Form-64.

NOTE: Excludes administrative costs and disproportionate share payments.

State variation in expenditures

Medicaid expenditures vary considerably from State to State for a number of reasons: the size and makeup of the beneficiary population, the coverage of optional services, the use of services by beneficiaries, and provider payment levels. In addition, some States have raised DSH payments substantially by taking advantage of certain financing schemes, whereas others have not. Because of those factors, total Medicaid expenditures vary much more widely among the States than might be expected, given the relative size of their low-income populations (see Table A–1 in the appendix). In California, for example, about 5.5 million people on average were in families with income below the poverty level over the 1990–1992 period compared with about 3 million in New York.[1] But in 1993, New York spent $18 billion on Medicaid, excluding administrative costs, whereas California spent only $14 billion.

In addition to the other factors contributing to program variation, differential use of DSH payments helps to account for the varying growth rates in Medicaid spending among the States (see Table A–2). For example, over the 1988–1993 period, the average annual growth rate of Medicaid spending was 14 percent in Massachusetts and 33 percent in Louisiana. In 1993, DSH payments were $484 million, about 12 percent of Medicaid expenditures, in Massachusetts compared with $1.2 billion, about one-third of Medicaid expenditures, in Louisiana.

For some of the reasons already cited, Medicaid expenditures per enrollee also vary widely among the States, ranging from less than $2,000 in Alabama, California, and Mississippi in 1993 to more than $5,000 in New York, excluding DSH payments. The extent to which the quality of services varies, however, is not easy to discern.

TRENDS IN SPENDING

Since 1975, the growth of Medicaid expenditures has been uneven, and recent patterns of growth have not reflected those of Medicare, private health insurance, or national health expenditures (see Table 2).[2] The trend in Medicaid expenditures for the 1975–1993 period can actually be divided into three distinct periods for analytic purposes: 1975 to 1981, when Medicaid spending grew rapidly but still remained at virtually the same rate as national health expenditures; 1981 to 1988, when Medicaid spending grew relatively slowly and less rapidly than national health expenditures; and 1988 to 1993, when Medicaid spending grew extremely rapidly and much faster than national health expenditures.

[1] Colin Winterbottom, David W. Liska, and Karen M. Obermaier, "State-Level Databook on Health Care Access and Financing," Washington, DC: Urban Institute, 1995.

[2] CBO's analysis of spending trends is based on data from the national health accounts. In developing those estimates, the Health Care Financing Administration reduced the amount of disproportionate share payments to hospitals when such payments were offset by taxes and donations paid by the same facilities. The effect is to reduce the estimates of State Medicaid spending in the 1990's below the levels actually reported by the States. See Katherine R. Levit and others, "National Health Spending Trends, 1960–1993," Health Affairs, vol. 13 (winter 1994), pp. 14–31.

TABLE 2. NATIONAL HEALTH EXPENDITURES BY SOURCE OF PAYMENT, 1975-1993 (By calendar year)

Source of Payment	1975	1980	1985	1990	1993
Billions of Dollars					
National Health Expenditures	132.6	251.1	434.5	696.6	884.2
Private health insurance	32.0	72.1	139.8	236.9	296.1
Medicare	16.4	37.5	72.2	112.1	154.2
Medicaid	13.5	26.1	41.3	75.4	117.9
Federal	7.4	14.5	22.8	42.7	76.1
State and local	6.1	11.6	18.4	32.7	41.8
Other	70.7	115.3	181.2	272.1	316.0
Average Annual Growth Rate from Previous Year Shown (Percent)					
National Health Expenditures	n.a.	13.6	11.6	9.9	8.3
Private health insurance	n.a.	17.6	14.2	11.1	7.7
Medicare	n.a.	18.0	14.0	9.2	11.2
Medicaid	n.a.	14.1	9.6	12.8	16.0
Federal	n.a.	14.3	9.5	13.3	21.2
State and local	n.a.	13.9	9.7	12.2	8.5
Other	n.a.	10.3	9.5	8.5	5.1

	1975-1981	1981-1988	1988-1993
Average Annual Growth Rate Over Indicated Periods (Percent)			
National Health Expenditures	14.0	9.8	9.5
Private health insurance	17.7	11.7	9.9
Medicare	18.3	10.3	11.5
Medicaid	14.5	8.9	16.4
Federal	15.0	8.8	19.6
State and local	13.8	9.0	11.7
Other	10.8	8.6	6.3

SOURCE: Congressional Budget Office based on data from the Health Care Financing Administration, Office of National Health Statistics.

NOTE: n.a. = not applicable.

Between 1975 and 1981, Medicaid spending grew at about 14 percent a year, the same as national health expenditures. Private health insurance and Medicare expenditures both grew at about 18 percent a year during that period. Since the num-

ber of beneficiaries remained virtually unchanged at around 22 million, the growth in Medicaid spending was attributable to increases in prices and utilization per beneficiary.

Medicaid expenditures grew relatively slowly during the 1981–1988 period, at an annual rate of about 9 percent. Medicare and private health insurance spending grew at 10 percent and 12 percent, respectively, and national health expenditures grew at about 10 percent. As in the previous period, the growth in Medicaid expenditures primarily reflected price increases and increases in utilization per beneficiary; the number of beneficiaries grew only slightly during the period, reaching about 23 million in 1988. Indeed, in spite of the effects of the 1981–1982 recession, the number of Medicaid beneficiaries actually fell slightly between 1981 and 1983. Factors contributing to that decline probably included cutbacks in the AFDC program enacted in the Omnibus Budget Reconciliation Act of 1981 combined with new Medicaid options that granted States greater flexibility in determining which groups of children to cover. Although the Congress authorized expansions in eligibility for children and pregnant women beginning in 1984, the early expansions were tied to categorical eligibility for welfare and did not have a major impact on the number of beneficiaries.

The 1988–1993 trends represented a break with the historical precedent of growth in Medicaid spending, trailing behind that of private health insurance and Medicare. In fact, Medicaid expenditures soared, rising at an average annual rate of more than 16 percent, although national health expenditures grew at less than 10 percent. By contrast, private health insurance expenditures grew at about 10 percent during the period, and Medicare spending grew at less than 12 percent. The most striking increases occurred between 1990 and 1992, when Medicaid spending jumped by over 40 percent. Several factors contributed to Medicaid's dramatic growth: sharp rises in Medicaid enrollment, payment increases for providers, and financing schemes and disproportionate share payments. But isolating their separate and interactive effects is difficult.

Rapid increases in Medicaid enrollment

In contrast to earlier periods, 1988 to 1993 was marked by swift growth in the number of Medicaid beneficiaries. Not only were there large increases in the number of children covered by the program, but there was also rapid growth in the enrollment of population groups that are more costly to serve.

Expansions in eligibility

Beginning in 1984 and continuing through 1990, the Congress authorized a series of mandatory and optional expansions in Medicaid eligibility. Low-income children and pregnant women were the primary focus of those expansions, but the target populations also included the elderly and the disabled.

Of particular importance were the options granted to the States in the Omnibus Budget Reconciliation Act of 1986, which severed the required link between Medicaid and welfare eligibility. A rapid succession of mandates and options for covering low-income children and pregnant women followed, as well as requirements for covering low-income Medicare beneficiaries. The most recent mandatory expansion of the program, authorized in the Omnibus Budget Reconciliation Act of 1990, requires States to provide coverage to all poor children under 19 who were born after September 30, 1983. That requirement means that mandatory expansions in Medicaid eligibility will continue under current law through 2002.

Such expansions in eligibility, along with efforts to streamline the eligibility process, have brought about large increases in the number of Medicaid beneficiaries who do not receive cash welfare benefits. The number of those beneficiaries rose at an average annual rate of about 17 percent between 1988 and 1993, having risen at an average rate of about 3 percent between 1981 and 1988. By 1993, over 40 percent of Medicaid beneficiaries did not receive cash welfare benefits, compared with less than 30 percent in 1988. Much of that increase, however, was among children, who are the least expensive beneficiaries to cover, and the proportion of total expenditures attributable to beneficiaries who do not receive cash benefits increased only slightly over the period.

Effects of the recession

The 1990–1991 recession sparked greater enrollment in the Medicaid program because more families received cash welfare benefits and fewer families had access to employer-sponsored health insurance. Determining the magnitude of the effects of the recession, however, is extremely hard to do.

The number of Medicaid beneficiaries who received cash welfare payments remained virtually constant at about 16.5 million throughout the 1980's. Consistent with the effects of a recession, that number increased to 17.2 million in 1991 and

18.8 million in 1992. But the number continued to rise to 19.6 million in 1993, even when the economy was expanding. Moreover, to some extent, the growth in the enrollment of Medicaid beneficiaries who were eligible for cash welfare benefits itself spurred growth in welfare caseloads. Some States began conducting aggressive outreach efforts to enroll children and pregnant women in Medicaid in the early 1990's and, in so doing, identified families who were eligible for cash welfare benefits but were not receiving them.

The recession also contributed to the enrollment of other low-income individuals and families in the Medicaid program, as they lost their jobs or faced reduced hours of work. It would be a formidable task, however, to disentangle the effects of the recession from the effects of the expansions in eligibility that were occurring at the same time.

Increases in high-cost beneficiaries

Medicaid expenditures depend not only on the total number of beneficiaries but also on their distribution among the different categories of eligibility. For a given number of beneficiaries, the higher the proportion of elderly and disabled beneficiaries, the greater spending will be. The proportion of pregnant women among the nondisabled adult population also has an important impact on spending.

The number of disabled Medicaid beneficiaries expanded rapidly in the early 1990's, rising from 3.5 million in 1988 to 5 million in 1993—an increase of 44 percent, or about 7.5 percent per year (see Table 3). Over that period, Medicaid expenditures for the disabled grew from about $19 billion to about $40 billion—an increase of over 100 percent. Thus, in spite of the large increases in the number of children covered by the program, the disabled population still represented 15 percent of total Medicaid beneficiaries in 1993, as it had in 1988, and accounted for almost the same proportion of total spending, excluding DSH payments. Several factors contributed to the growth in the disabled population, including expansions of the Supplemental Security Income program for children and increasing numbers of beneficiaries with AIDS and mental illness. The number of disabled beneficiaries is expected to expand more rapidly than total beneficiaries for the remainder of the decade.

TABLE 3. GROWTH IN MEDICAID BENEFICIARIES AND EXPENDITURES, 1988-1993 (By fiscal year)

	Average Annual Rate of Growth, 1988-1993 (In percent)	
	Beneficiaries	Expenditures
Elderly	4.1	13.3
Cash recipients	-1.5	9.6
Other beneficiaries	9.2	14.5
Disabled	7.5	15.7
Cash recipients	6.2	16.0
Other beneficiaries	12.2	15.2
Adults	6.4	19.3
Cash recipients	2.6	13.2
Other beneficiaries	15.0	33.7
Children	10.2	24.1
Cash recipients	3.6	16.5
Other beneficiaries	27.6	41.4

SOURCE: Congressional Budget Office estimates based on data from the Health Care Financing Administration, HCFA Form-2082 and HCFA Form-64.

NOTE: Expenditures exclude administrative costs and disproportionate share payments.

The expansions in eligibility for pregnant women during the 1988–1993 period also brought into the Medicaid program a beneficiary group that, by definition, had extensive acute medical care needs. The number of nondisabled adult beneficiaries who did not receive cash welfare payments more than doubled over the period, from 1.4 million to 2.9 million—and payments for that group rose from $1.5 billion to $6.5 billion.

Increases in payments to providers

During the 1980's, providers in several States filed lawsuits challenging the reasonableness and adequacy of reimbursement rates for hospitals and nursing homes. Those lawsuits were filed under the Boren amendment—originally enacted as part of the Omnibus Reconciliation Act of 1980 and expanded in the Omnibus Budget Reconciliation Act of 1981—which required States to pay rates that were "reasonable and adequate" to meet those costs that would be incurred by "efficiently and economically operated" facilities. A decision by the U.S. Supreme Court in 1990 established that providers have an enforceable right to such rates and that they may sue State officials for declaratory and injunctive relief.

Following the Supreme Court's ruling, decisions favoring providers were handed down in several States. Moreover, the mere threat of suit under the Boren amendment may have been sufficient to make some States increase payments. Consequently, in the early 1990's, payments to hospitals and nursing homes rose substantially in some States. Despite recent court decisions favoring the States in suits brought under the Boren amendment, the National Governors Association is trying to have the amendment repealed, believing that it significantly limits the ability of the States to control Medicaid expenditures.

Financing schemes and disproportionate share payments

In the late 1980's and early 1990's, faced with burgeoning Medicaid costs and pressures to increase their reimbursement rates for providers, many States developed financing schemes to generate part of their share of Medicaid expenditures. Those schemes, which involved voluntary donations from providers, taxes on providers, and intergovernmental transfers, drew down Federal matching dollars for what were often illusory Medicaid expenditures.[3] Such financing mechanisms were closely associated with the rapid growth in DSH payments that occurred during the period, sometimes as a response to actual or potential litigation under the Boren amendment. According to researchers at the Urban Institute, DSH payments rose from less than $1 billion in 1990 to more than $17 billion in 1992.[4] But some of those amounts were almost certainly offset by taxes or donations from providers.

The Congress took action in 1991 to limit the use of provider taxes and donations and also to place a cap on the growth of DSH payments. Further restrictions on DSH payments were enacted in the Omnibus Budget Reconciliation Act of 1993. It is still too early to assess the full impact of those provisions, but DSH payments fell in 1993 and 1994 and rapid growth in the future is unlikely.

FACTORS CONTRIBUTING TO FUTURE GROWTH IN EXPENDITURES

The future growth of Medicaid expenditures under current law will be critically affected by expansions in eligibility, changes in the mix of Medicaid beneficiaries, and the success of efforts by the States to control Medicaid spending through expanding enrollment in managed care plans. Considerable uncertainty surrounds all of those issues.

Expansions in eligibility

Some expansions in eligibility will occur because of the current-law mandate to phase in coverage of poor children. Since children are the least costly group of Medicaid beneficiaries and only one age cohort is being added each year, the mandate is not expected to prompt rapid growth in expenditures.

Expansions in eligibility that are undertaken at the option of the States are much more difficult to predict. Several States have recently taken advantage of a provision in section 1902(r)(2) of the Social Security Act that enables them to expand coverage to children and pregnant women in families whose income is considerably higher than the levels nominally permitted by legislation. Moreover, several States have obtained—or are seeking—waivers from Medicaid regulations in order to expand insurance coverage to poor and near-poor population groups. Although such expansions are supposed to be budget neutral, the Health Care Financing Administration [HCFA] is allowing States to incorporate hypothetical expansions of eligibility under section 1902(r)(2) into their Medicaid baselines for purposes of establishing budget neutrality.

To date, 8 States have had waivers approved, a further 11 States have applications pending, and others are considering applying. The eight approved States include Arizona, which has always operated its Medicaid program under a statewide demonstration waiver. At least four of the recently approved statewide waivers incorporated expansions of eligibility into the State's baseline expenditures.

Note, however, that not all waivers that are approved will actually be implemented. Kentucky, for example, had a waiver approved by HCFA to enable the State to expand coverage to other low-income groups. But the State legislature stipulated that the Medicaid program had to prove that it could generate sufficient savings to cover the expanded eligibility before such expansions could occur. To date, therefore, no expansion in eligibility has occurred. Nor will all the States that are considering applying in order to expand coverage actually do so, especially given the current uncertainty about the future course of the Medicaid program. Indeed, some States, such as New York, may actually be trying to cut their Medicaid budgets.

Changing mix of beneficiaries

As mentioned previously, the number of disabled Medicaid beneficiaries is expected to continue to increase quite rapidly—from about 6 million in 1995 to 8.3 million in 2002, or at an average annual rate of 4.9 percent. Total beneficiaries are expected to grow at an annual rate of only 3.2 percent during that period. The rapid growth in the number of disabled beneficiaries reflects the continuing effects of outreach to the affected populations by the Social Security Administration, a broader

[3] General Accounting Office, "Medicaid: States Use Illusory Methods to Shift Program Costs to the Federal Government," August 1994.

[4] John Holahan, David Liska, and Karen Obermaier, "Medicaid Expenditures and Beneficiary Trends, 1988–1993," Washington, DC: Urban Institute, September 1994.

definition of disability than in earlier years, and the growing number of individuals reaching ages at which there is a high incidence of disability. Those factors are resulting in increasing numbers of both cash welfare recipients and others who do not receive cash welfare benefits.

Growth of managed care

Many States are moving quickly to enroll Medicaid beneficiaries in managed care plans, both to improve access and to control costs. The evidence to date, however, on the effectiveness of managed care in containing Medicaid costs is limited.[5] Moreover, most States have concentrated thus far on developing managed care options for children and nondisabled adults, and those groups account for only about one-third of Medicaid spending. It will be much tougher to develop appropriate and cost-saving models of managed care for elderly and disabled beneficiaries, who account for the bulk of Medicaid expenditures.[6] Arizona enrolls both AFDC and SSI beneficiaries in prepaid health plans, and Tennessee is attempting to cover all noninstitutionalized Medicaid beneficiaries under its statewide section 1115 waiver. In addition, a few other States are developing managed care options for the elderly and disabled, in some cases incorporating both acute and long-term care services. But the widespread enrollment of elderly and disabled Medicaid beneficiaries in managed care plans seems unlikely in the immediate future.

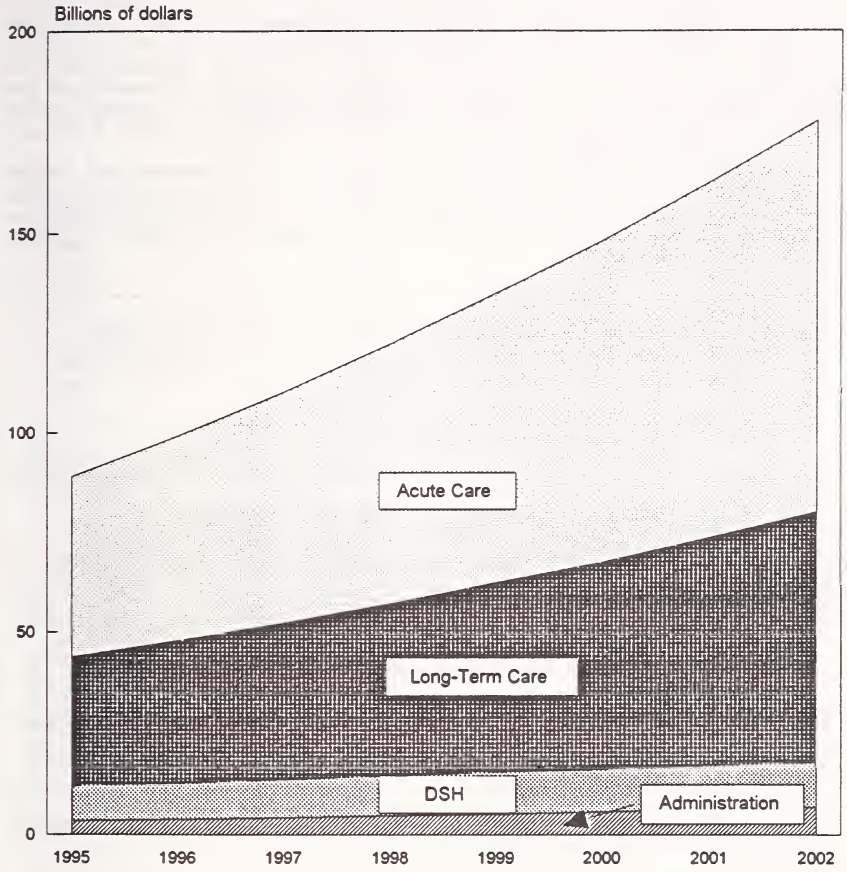
CBO'S SPENDING PROJECTIONS

Under current law, CBO projects that the Federal share of Medicaid payments will rise from $89 billion in 1995 to $178 billion in 2002, which represents an average annual rate of growth of 10.4 percent (see Figure 6). Most of that increase stems from the growth in payments for acute and long-term care benefits, with DSH payments rising only slowly during the period.

[5] Robert E. Hurley, Deborah A. Freund, and John E. Paul, "Managed Care in Medicaid: Lessons for Policy and Program Design," Ann Arbor, MI: Health Administration Press, 1993.

[6] Deborah A. Freund and Robert E. Hurley, "Medicaid Managed Care: Contribution to Issues of Health Reform," Annual Reviews of Public Health, vol. 16 (1995), pp. 473–495.

FIGURE 6.—PROJECTIONS OF FEDERAL MEDICAID SPENDING, FISCAL YEARS 1995–2002



SOURCE: Congressional Budget Office.

NOTE: DSH = disproportionate share hospital payments.

Three primary factors drive CBO's projections of Medicaid expenditures for the next several years: growth in the number of beneficiaries, price increases, and residual growth. The total number of beneficiaries is expected to increase by 4 percent in 1995, slowing to about 2.5 percent by 2002. But the number of aged and disabled beneficiaries is expected to grow faster than the total. Accounting for that change in composition, about 40 percent of projected overall Medicaid growth can be attributed to increases in caseload.

CBO uses different inflation factors for different categories of Medicaid expenditures. On average, those factors are expected to increase at about 4 percent a year. Over the 1995–2002 period, changes in prices account for approximately 30 percent of the projected increase in Medicaid outlays.

Finally, the projections assume that all other factors combined—excluding DSH payments—will increase Medicaid spending by about 2 percent in 1995 and 3 percent a year for the remainder of the period. That residual growth factor, which accounts for about 25 percent of overall Medicaid growth, encompasses changes in uti-

lization, the use of more complex technologies, changes in the benefit packages that States offer, and increases in payment rates above general inflation.

CBO's current Medicaid projections are somewhat lower than those it made last summer. The current estimate of 1994 Federal Medicaid spending is about $82 billion, or about $2 billion lower than CBO's summer projection. Similarly, the current projection for 1995 is $89 billion, or about $7 billion lower than the summer projection. Because 1994 Medicaid spending was lower than CBO had projected, CBO has lowered the starting level of Medicaid expenditures on which the projections are based. Change in that level accounts for much of the change in expected outlays. CBO has also lowered the assumed rate of growth of spending by about 1 percentage point beginning in 1996.

The Medicaid projections developed by the Office of Management and Budget [OMB] are lower than CBO's (see Table 4). OMB assumed that lower-than-anticipated spending in 1994 represented a change in the program that will be sustained throughout the projection period. By contrast, CBO projects that growth will return to more historical levels.

TABLE 4. COMPARISON OF CONGRESSIONAL BUDGET OFFICE AND OFFICE OF MANAGEMENT AND BUDGET MEDICAID PROJECTIONS (By fiscal year)

	1994	1995	1996	1997	1998	1999	2000
Projected Outlays for Medicaid (In billions of dollars)							
Congressional Budget Office	82.0	89.2	99.3	110.0	122.1	134.8	148.1
Office of Management and Budget	82.0	88.4	96.0	104.6	114.5	124.5	136.3
Difference in Outlays	0	0.8	3.3	5.4	7.6	10.3	11.8
Projected Rate of Growth of Outlays (In percent)							
Congressional Budget Office	n.a.	8.8	11.3	10.8	10.9	10.5	9.9
Office of Management and Budget	n.a.	7.8	8.6	9.0	9.5	8.7	9.5

SOURCES: Congressional Budget Office February 1995 baseline and Office of Management and Budget, *Budget of the United States Government, Fiscal Year 1996.*

NOTE: n.a. = not applicable.

CONCLUSION

Many of the Nation's Governors are now seeking less Federal control of the Medicaid program to enable the States to meet the needs of their particular low-income populations more effectively. The States' desire for greater flexibility plus the ongoing rapid growth of spending make the Medicaid program potentially ripe for change. How to limit program growth without adverse effects on the intended beneficiaries is the challenge facing the Congress and the States.

APPENDIX.—STATE MEDICAID AND POVERTY DATA

TABLE A-1. STATE STATISTICS ON MEDICAID EXPENDITURES AND POVERTY

State	Total Medicaid Expenditures, 1993 (In millions of dollars)	Federal Medicaid Expenditures, 1993 (In millions of dollars)	Percentage of All Federal Medicaid Expenditures, 1993	Federal Matching Percentage, 1993	Poverty Population, 1990-1992 (In thousands)	Percentage of U.S. Poverty Population, 1990-1992
Alaska	301.1	160.6	0.2	50.0	80	0.2
Alabama	1,635.9	1,170.9	1.6	71.5	788	2.0
Arkansas	1,017.8	758.0	1.0	74.4	426	1.1
Arizona	1,375.4	918.3	1.3	65.9	535	1.4
California	14,060.9	7,043.4	9.8	50.0	5,487	13.9
Colorado	1,281.1	700.5	1.0	54.4	401	1.0
Connecticut	1,992.9	999.8	1.4	50.0	259	0.7
District of Columbia	654.6	327.7	0.5	50.0	130	0.3
Delaware	251.0	126.2	0.2	50.0	73	0.2
Florida	4,861.8	2,680.7	3.7	55.0	2,243	5.7
Georgia	2,766.1	1,723.8	2.4	62.1	1,184	3.0
Hawaii	385.7	193.6	0.3	50.0	141	0.4
Iowa	959.0	603.8	0.8	62.7	322	0.8
Idaho	291.0	207.7	0.3	71.2	158	0.4
Illinois	4,908.1	2,461.9	3.4	50.0	1,948	4.9
Indiana	2,785.7	1,763.4	2.4	63.2	734	1.9
Kansas	1,073.4	624.5	0.9	58.2	302	0.8
Kentucky	1,823.7	1,309.3	1.8	71.7	680	1.7
Louisiana	3,906.3	2,888.3	4.0	73.7	975	2.5
Massachusetts	3,976.1	1,996.8	2.8	50.0	724	1.8
Maryland	1,972.2	989.8	1.4	50.0	621	1.6
Maine	827.9	511.9	0.7	61.8	179	0.5
Michigan	4,403.5	2,465.8	3.4	55.8	1,585	4.0
Minnesota	2,138.8	1,184.5	1.6	54.9	542	1.4
Missouri	2,244.6	1,356.5	1.9	60.6	786	2.0
Mississippi	1,175.2	928.9	1.3	79.0	658	1.7
Montana	328.0	235.6	0.3	70.9	134	0.3
North Carolina	2,839.0	1,875.3	2.6	65.9	1,004	2.5
North Dakota	258.2	188.6	0.3	72.2	82	0.2
Nebraska	560.0	344.2	0.5	61.3	171	0.4
New Hampshire	412.3	207.3	0.3	50.0	108	0.3
New Jersey	4,883.0	2,447.0	3.4	50.0	898	2.3
New Mexico	582.2	434.0	0.6	73.9	334	0.8
Nevada	389.6	205.2	0.3	52.3	175	0.4
New York	18,015.0	9,033.3	12.5	50.0	2,972	7.5
Ohio	5,161.5	3,114.7	4.3	60.3	1,502	3.8
Oklahoma	1,075.8	753.4	1.0	69.7	519	1.3
Oregon	946.8	592.3	0.8	62.4	354	0.9
Pennsylvania	6,468.0	3,599.2	5.0	55.5	1,561	4.0
Rhode Island	820.4	440.7	0.6	53.6	116	0.3
South Carolina	1,639.4	1,170.8	1.6	71.3	671	1.7
South Dakota	264.0	188.0	0.3	70.3	102	0.3
Tennessee	2,645.3	1,787.7	2.5	67.6	921	2.3
Texas	7,030.3	4,544.2	6.3	64.4	3,260	8.3
Utah	475.5	358.2	0.5	75.3	204	0.5
Virginia	1,788.5	898.0	1.2	50.0	841	2.1
Vermont	259.2	155.9	0.2	59.9	63	0.2
Washington	2,263.1	1,249.8	1.7	55.0	578	1.5
Wisconsin	2,094.0	1,269.7	1.8	60.4	543	1.4
West Virginia	1,199.7	915.6	1.3	76.3	366	0.9
Wyoming	133.1	90.0	0.1	67.1	52	0.1

SOURCE: Health Care Financing Administration, HCFA Form-64; and Colin Winterbottom, David W. Liska, and Karen M. Obermaier, *State-Level Databook on Health Care Access and Financing* (Washington, D.C.: Urban Institute, 1995).

NOTE: Expenditures do not include administrative costs. Totals do not include U.S. territories. Expenditure data are for fiscal years. Poverty data are based on calendar years.

TABLE A-2. MEDICAID EXPENDITURES BY STATE, 1988 AND 1993 (By fiscal year)

State	Total Medicaid Expenditures, 1988 (In millions of dollars)	Total Medicaid Expenditures, 1993 (In millions of dollars)	Average Annual Rate of Growth, 1988-1993	Percentage of Total Medicaid Expenditures, 1988	Percentage of Total Medicaid Expenditures, 1993
Alaska	102.8	301.1	24.0	0.2	0.2
Alabama	466.8	1,635.9	28.5	0.9	1.3
Arkansas	428.4	1,017.8	18.9	0.8	0.8
Arizona	183.1	1,375.4	49.7	0.4	1.1
California	5,592.7	14,060.9	20.0	10.9	11.2
Colorado	480.9	1,281.1	26.1	0.9	1.0
Connecticut	834.7	1,992.9	19.0	1.6	1.6
District of Columbia	379.2	654.6	11.5	0.7	0.5
Delaware	100.9	251.0	20.2	0.2	0.2
Florida	1,524.7	4,861.8	26.1	3.0	3.9
Georgia	1,136.0	2,766.1	19.5	2.2	2.2
Hawaii	159.8	385.7	19.3	0.3	0.3
Iowa	477.1	959.0	15.0	0.9	0.8
Idaho	118.5	291.0	19.7	0.2	0.2
Illinois	1,915.0	4,908.1	20.7	3.7	3.9
Indiana	1,024.0	2,785.7	22.2	2.0	2.2
Kansas	328.9	1,073.4	26.7	0.6	0.9
Kentucky	714.2	1,823.7	20.6	1.4	1.5
Louisiana	939.4	3,906.3	33.0	1.8	3.1
Massachusetts	2,078.4	3,976.1	13.9	4.0	3.2
Maryland	931.2	1,972.2	16.2	1.8	1.6
Maine	325.4	827.9	20.5	0.6	0.7
Michigan	2,047.5	4,403.5	16.6	4.0	3.5
Minnesota	1,183.2	2,138.8	12.6	2.3	1.7
Missouri	714.7	2,244.6	25.7	1.4	1.8
Mississippi	443.9	1,175.2	21.5	0.9	0.9
Montana	152.1	328.0	16.6	0.3	0.3
North Carolina	965.7	2,839.0	24.1	1.9	2.3
North Dakota	159.6	258.2	10.1	0.3	0.2
Nebraska	240.8	560.0	18.4	0.5	0.4
New Hampshire	172.0	412.3	19.1	0.3	0.3
New Jersey	1,748.2	4,883.0	22.8	3.4	3.9
New Mexico	229.0	582.2	20.5	0.4	0.5
Nevada	96.5	389.6	32.2	0.2	0.3
New York	9,717.2	18,015.0	13.1	18.9	14.3
Ohio	2,363.5	5,161.5	16.9	4.6	4.1
Oklahoma	593.1	1,075.8	12.6	1.2	0.9
Oregon	364.6	946.8	21.0	0.7	0.8
Pennsylvania	2,544.0	6,468.0	20.5	4.9	5.1
Rhode Island	334.0	820.4	19.7	0.6	0.7
South Carolina	472.3	1,639.4	28.3	0.9	1.3
South Dakota	125.9	264.0	16.0	0.2	0.2
Tennessee	1,009.5	2,645.3	21.2	2.0	2.1
Texas	2,017.2	7,030.3	28.4	3.9	5.6
Utah	196.6	475.5	19.3	0.4	0.4
Virginia	776.3	1,788.5	18.2	1.5	1.4
Vermont	113.4	259.2	18.0	0.2	0.2
Washington	932.1	2,263.1	19.4	1.8	1.8
Wisconsin	1,139.0	2,094.0	13.0	2.2	1.7
West Virginia	315.0	1,199.7	30.7	0.6	1.0
Wyoming	46.7	133.1	23.3	0.1	0.1

SOURCE: Health Care Financing Administration, HCFA Form-64.

NOTE: Expenditures do not include administrative costs. Totals do not include U.S. territories.

Mr. KOLBE. Thank you very much, Dr. O'Neill.

Several things about your testimony are very interesting here. I was particularly struck; you keep coming back to the DSH payments, the disproportionate share. But in your conclusion, you say

that that is going to be less of a factor in future cost runups; is that correct?

Ms. O'NEILL. That is because measures were taken legislatively in 1993——

Mr. KOLBE. My question is, did we close the——

Ms. O'NEILL. Oh, did we completely close——

Mr. KOLBE. No. Did we close the barn door after the horse was out?

Ms. O'NEILL. I am not sure if it is—DSH payments still exist and there is now a cap of 12 percent, which may strike some as too high and others as OK.

Mr. KOLBE. Have we built into the base a dangerously high level?

Ms. O'NEILL. We are assuming that DSH payments will continue to be around. That is true.

Mr. KOLBE. In your view, though, however——

Ms. O'NEILL. Whether it——

Mr. KOLBE [continuing]. What happened in the past, is it built now into the base as a factor of driving up these costs? Is it a significant factor in the high—the fact that we ran the costs up earlier is now built into the base?

Ms. O'NEILL. No. That is certainly true. It has been built into the base. We are projecting what we expect to happen if there were no further changes in legislation. It is very difficult to imagine that, especially in the current environment in which States suspect that there may be changes coming.

In the context of Medicaid, the baseline is subject to more uncertainty than I think would usually be the case.

Mr. KOLBE. You also spoke on disability as one of the major factors in the future here. Can you give us some indication of what the rise in the number of individuals that qualify for disability payments is?

Ms. O'NEILL. I can tell you——

Mr. KOLBE. I am curious about the aggregate figures. It doesn't strike me—what I am driving at is it doesn't strike me that we have had a huge increase in the number of disabled in this country, but what we have done is increase the number who qualify as disabled.

Ms. O'NEILL. In part, that is tied to the growth in the SSI disabled population, which is significant.

Mr. KOLBE. I guess the question is, the actual numbers haven't increased, but it is those that are categorized as being eligible.

Ms. O'NEILL. Not entirely. To some extent. There is some natural increase in the number of disabled people in the population because the baby boomers are now getting into the ages in which they experience more disabilities. After a long period during which the disabled population might not have grown, there is some natural increase.

Mr. KOLBE. But a large part of that has to do with States being more aggressive in qualifying people; is that not correct?

Ms. O'NEILL. That is the other part of it.

Mr. KOLBE. Is that a cost shifting that is going on? That is what I am trying to get at.

Ms. O'NEILL. There is a natural component. Then there is a second component based on changes in definitions of eligibility, and that may vary from State to State, as Medicaid is essentially a State-controlled program. A third reason for program growth stems from growth in the SSI program, which then feeds into the Medicaid program.

Mr. KOLBE. One more question before my time expires here. You spoke about the fact that the period 1988 to 1993 was supposed to be a period of sharing between States and the Federal Government in Medicaid.

Ms. O'NEILL. That was a period of extraordinarily rapid growth.

Mr. KOLBE. Growth, I know. But it was also supposed to be a period of more equitable sharing of the costs between States and the Federal Government; is that not correct?

Ms. O'NEILL. I think that it was a period of time during which the program was expanded, in part because of legislation, which brought in new groups of eligible beneficiaries.

Mr. KOLBE. Well, on your Table 2, your National Health Expenditures by Source of Payment, you have a very dramatic difference down there where it shows average annual growth rate over indicated periods. In the Federal and the State and the local contributions, 19 percent——

Ms. O'NEILL. Oh, I am sorry. I thought you were asking if I thought this was equitable, which is sort of a value judgment. But the Federal share increased, that is true.

Mr. KOLBE. What caused that tremendous jump in the Federal share during that period?

Ms. O'NEILL. We haven't analyzed this in detail, but a good bet is that DSH payments contributed to the rising Federal share, because that was a way to generate more Federal revenues for States.

Mr. KOLBE. I am sorry. What was a way of generating more Federal revenues?

Ms. O'NEILL. DSH payments.

Mr. KOLBE. DSH payments.

Ms. O'NEILL. In combination with State measures to put into effect donation and tax schemes; that is, donations were sort of a euphemism. It was a required donation. States required hospitals to make donations to the State or to pay special taxes that applied to health care providers only.

Mr. KOLBE. Right.

Ms. O'NEILL. Outright taxes. And then those were used to generate disproportionate share payments which had a Federal match. So through these very complicated kinds of transactions, there was a mechanism for boosting the Federal share.

Mr. KOLBE. So you are saying the DSH payments more than anything else are responsible for that huge jump from——

Ms. O'NEILL. I don't think the Federal share increased because of some spontaneous happening. It was more because of payments like DSH that aren't tied to a particular service.

Mr. KOLBE. I am just trying to get an understanding. If you look at earlier periods, 1975–81—I am on page 14 of your testimony, Table 2 there—the period 1975–81 and 1981–88, the proportions are relatively—in fact, in the middle period, the State and local

share grew slightly faster. But then there is a significant jump. It is not that the State growth went down. It actually went up. But the Federal share doubled in the period 1988–93.

Ms. O'NEILL. Yes, and that is an enormous rate of increase. The Federal share was increasing at a rate of close to 20 percent a year, which is really a galloping increase.

Mr. KOLBE. When you compound that, it is staggering, yes.

Ms. O'NEILL. Right.

Mr. KOLBE. Thank you.

Mr. Sabo.

Mr. SABO. I am curious in dealing with the DSH problem, clearly some States game the system better than others—or worse than others, however you want to describe it. A year ago, I looked at DSH payments for a State about the size of Minnesota, and I went up to the Midwest and I added up Illinois, Michigan, Wisconsin, Minnesota, Iowa, North and South Dakota, Kansas, Nebraska, before I arrived at a total of DSH payments that that one State had received. Something seemed out of proportion.

I am just curious. I keep reading that Congress may turn Medicaid into a block grant in some fashion. There is always a tendency to grandfather when you do that. Do you have any ideas how you pull DSH payments out and how you redistribute those payments in terms of developing a base for any proposal for block grants?

Ms. O'NEILL. That is a good question. I think that sensitivity to the variation in DSH payments would certainly be appropriate, because they vary. We know how much each State generates in DSH payments, and some——

Mr. SABO. Is that chart in here, by any chance?

Ms. O'NEILL. No, but I have a chart in front of me that appeared in the Federal Register in January 1995, and I would be happy to submit it for the record.

[The information requested follows:]

In response to your request, we are including for the record a recent announcement in the Federal Register concerning States' 1995 disproportionate share allotments.

petitioner's environmental assessment without further announcement in the **Federal Register**. If, based on its review, the agency finds that an environmental impact statement is not required and this petition results in a regulation, the notice of availability of the agency's finding of no significant impact and the evidence supporting that finding will be published with the regulation in the **Federal Register** in accordance with 21 CFR 25.40(c).

Dated: January 6, 1995.

Alan M. Rulis,

Acting Director, Office of Premarket Approval, Center for Food Safety and Applied Nutrition.

[FR Doc. 95–897 Filed 1–13–95; 8:45 am]

BILLING CODE 4160–01–F

Health Care Financing Administration

[MB–089–N]

RIN 0938–AG61

Medicaid Program; Limitations on Aggregate Payments to Disproportionate Share Hospitals: Federal Fiscal Year 1995

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Notice.

SUMMARY: This notice announces the preliminary Federal fiscal year (FFY) 1995 national target and individual State allotments for Medicaid payment adjustments made to hospitals that serve a disproportionate number of Medicaid recipients and low-income patients with special needs. We are publishing this notice in accordance with the provisions of section 1923(f)(1)(C) of the Social Security Act (the Act) and implementing regulations at 42 CFR 447.297 through 447.299. The preliminary FFY 1995 State DSH allotments published in this notice will be superseded by final FFY 1995 DSH allotments to be published in the **Federal Register** by April 1, 1995.

EFFECTIVE DATE: The preliminary DSH payment adjustment expenditure limits included in this notice apply to Medicaid DSH payment adjustments that are applicable to FFY 1995.

FOR FURTHER INFORMATION CONTACT: Richard Strauss, (410) 965–2019.

SUPPLEMENTARY INFORMATION:

I. Background

Section 1923(f) of the Social Security Act (the Act) and implementing Medicaid regulations at 42 CFR 447.297 through 447.299 require us to estimate and publish in the **Federal Register** the national target and each State's allotment for disproportionate hospital share (DSH) payments for each Federal fiscal year (FFY). DSH payments are payment adjustments made to Medicaid-participating hospitals that serve a large number of Medicaid recipients and other low-income individuals with special needs. Preliminary amounts must be published by October 1 of each FFY and final amounts by April 1 of each FFY.

The implementing regulations provide that the national aggregate DSH limit for a FFY is a target rather than an absolute cap when determining the amount that can be allocated for DSH payments. The national DSH target is 12 percent of the total amount of medical assistance expenditures (excluding total administrative costs) that are projected to be made under approved Medicaid State plans during the FFY. (Note: Whenever the phrases "total medical assistance expenditures" or "total administrative costs" are used in this notice, they mean both the State and Federal share of expenditures or costs.)

In addition to the national DSH target, there is a specific State DSH limit for each State for each FFY. The State DSH limit is a specified amount of DSH payment adjustments applicable to a FFY above which FFP will not be available. This is called the "State DSH allotment".

Each State's DSH allotment for FFY 1995 is calculated by first determining whether the State is a "high-DSH State," or a "low-DSH State." This is determined by using the State's "base allotment." A State's base allotment is the greater of: (1) The total amount of the State's actual and projected DSH payment adjustments made under the State's approved State plan applicable to FFY 1992, as adjusted by HCFA; or (2) $1,000,000.

A State whose base allotment exceeds 12 percent of the State's total medical assistance expenditures (excluding administrative costs) projected to be made in FFY 1995 is referred to as a "high-DSH State." The FFY 1995 State DSH allotment for a high-DSH State is limited to the State's base allotment.

A State whose base allotment is equal to or less than 12 percent of the State's total medical assistance expenditures (excluding administrative costs) projected to be made in FFY 1995 is referred to as a "low-DSH State." The FFY 1995 State DSH allotment for a low-DSH State is equal to the State's DSH allotment for FFY 1994 increased by growth amounts and supplemental amounts, if any. However, the FFY 1995 DSH allotment for a low-DSH State cannot exceed 12 percent of the State's total medical assistance expenditures for FFY 1995 (excluding administrative costs).

The growth amount for FFY 1995 is equal to the projected percentage increase (the growth factor) in a low-DSH State's total Medicaid program expenditures between FFY 1994 and FFY 1995 multiplied by the State's final DSH allotment for 1994. Because the national DSH limit is considered a target, a low-DSH State whose program grows from one year to the next can receive a growth amount that would not be permitted if the national limit was viewed as an absolute cap.

There is no growth factor and no growth amount for any low-DSH State whose Medicaid program does not grow (that is, stayed the same or declined) between fiscal years FFY 1994 and FFY 1995. Furthermore, because a low-DSH State's FFY 1995 DSH allotment cannot exceed 12 percent of the State's total medical assistance expenditures, it is possible for its FFY 1995 DSH allotment to be lower than its FFY 1994 DSH allotment. This situation occurs when the State experiences a decrease in its program expenditures between years and its prior FFY DSH allotment is greater than 12 percent of the total projected medical assistance expenditures for the current FFY. This situation did not occur for FFY 1995. Consequently, there are no States with preliminary FFY 1995 State DSH allotments that are lower than the final FFY 1994 State DSH allotments.

There is no supplemental amount available for redistribution for FFY 1995. The supplemental amount, if any, is equal to a low-DSH State's proportional share of a pool of funds (the redistribution pool). The redistribution pool is equal to the national 12-percent DSH target reduced by the total of the base allotments for high-DSH States, the total of the State DSH allotments for the previous FFY for low-DSH States, and the total of the low-DSH State growth amounts. Since the sum of these amounts is above the projected FFY 1995 national 12 percent DSH target, there is no redistribution pool and, therefore, no supplemental amounts for FFY 1995.

As prescribed in the law and regulations, no State's DSH allotment will be below a minimum of $1 million.

As an exception to the above requirements, under section 1923(f)(1)(A)(i)(II) of the Act and regulations at 42 CFR 447.296(b)(5) and 447.298(f), a State may make DSH payments for a FFY in accordance with the minimum payment adjustments required by Medicare methodology described in section 1923(c)(1) of the

Act. Nebraska's preliminary State DSH allotment has been determined in accordance with this exception.

We are publishing in this notice the preliminary FFY 1995 national DSH target and State DSH allotments based on the best available data we have at this time from the States as adjusted by HCFA. This data is taken from each State's August 1994 Form HCFA–37 and is adjusted as necessary. The final FFY 1995 DSH allotments will be published in the **Federal Register** by April 1, 1995.

II. Calculations of the Preliminary FFY 1995 DSH Limits

The total of the preliminary State DSH allotments for FFY 1995 is equal to the sum of the base allotments for all high-DSH States, the FFY 1994 State DSH allotments for all low-DSH States, and the growth amounts for all low-DSH States. A State-by-State breakdown is presented in section III of this notice.

We classified States as high-DSH or low-DSH States. If a State's base allotment exceeded 12 percent of its total unadjusted medical assistance expenditures (excluding administrative costs) projected to be made under the State's approved plan in FFY 1995, we classified that State as a "high-DSH" State. If a State's base allotment was 12 percent or less of its total unadjusted medical assistance expenditures projected to be made under the State's approved State plan under title XIX of the Act in FFY 1995, we classified that State as a "low-DSH" State. There are 34 low-DSH States and 16 high-DSH States for FFY 1995 as a result of this classification.

Using the most recent data from the August 1994 budget projections (Form HCFA–37), we estimate the States' FFY 1995 national total medical assistance expenditures to be $155,059,961,000. Thus, the overall preliminary national FFY 1995 DSH expenditure target is approximately $18.6 billion (12 percent of $155.1 billion).

In addition, in the preliminary FFY 1995 State DSH allotments we provide a total of $752,609,000 ($417,509,000 Federal share) in growth amounts for the 34 low-DSH States. The growth factor percentage for each of the low-DSH States was determined by calculating the Medicaid program growth percentage for each low-DSH State between FFY 1994 and FFY 1995. To compute this percentage, we first ascertained each low-DSH State's estimate of total FFY 1994 medical assistance and administrative expenditures as reported on the State's Medicaid Budget Report (Form HCFA–37) submitted in August 1994. Next, we compared those estimates to each low-DSH State's total estimated unadjusted FFY 1995 medical assistance and administrative expenditures as reported to HCFA on the State's August 1994 Form HCFA–37 submission.

The growth factor percentage was multiplied by the low-DSH State's final FFY 1994 DSH allotment amount to establish the State's preliminary growth amount for FFY 1995.

Since the sum of the total of the base allotments for high-DSH States, the total of the State DSH allotments for the previous FFY for low-DSH States, and the growth for low-DSH States ($19,242,708,000) is greater than the preliminary FFY 1995 national target ($18,607,195,000), there is no preliminary FFY 1995 redistribution pool.

The low-DSH State's growth amount was then added to the low-DSH State's final FFY 1994 DSH allotment amount to establish the preliminary total low-DSH State DSH allotment for FFY 1995. If a State's growth amount, when added to its final FFY 1994 DSH allotment amount, exceeds 12 percent of its FFY 1995 estimated medical assistance expenditures, the State only receives a partial growth amount which, when added to its final FFY 1994 allotment, limits its total State DSH allotment for FFY 1995 to 12 percent of its estimated FFY 1995 medical assistance expenditures. For this reason, seven of the low-DSH States received partial growth amounts.

As we explained above, in accordance with the minimum payment adjustments required by Medicare methodology, Nebraska's preliminary FFY 1995 State DSH allotment is $11 million.

In summary, the total of all preliminary State DSH allotments for FFY 1995 is $19,242,708,000 ($10,978,517,000 Federal share). This total is composed of the prior FFY's final State DSH allotments ($18,490,099,000) plus growth amounts for all low-DSH States ($752,609,000) plus supplemental amounts for low-DSH States ($0). The total of all preliminary FFY 1995 State DSH allotments is 12.6 percent of the total medical assistance expenditures (excluding administrative costs) projected to be made by these States in FFY 1995. The total of all preliminary DSH allotments for FFY 1995 is $635,513,000 over the FFY 1995 preliminary national target amount of $18,607,195,000.

Each State should monitor and make any necessary adjustments to its DSH spending during FFY 1995 to ensure that its actual FFY 1995 DSH payment adjustment expenditures do not exceed its final State DSH allotment for FFY 1995 which will be published by April 1, 1995. As the ongoing reconciliation between actual FFY 1995 DSH payment adjustment expenditures and the final FFY 1995 DSH allotments takes place, each State should amend its plans as may be necessary to make any adjustments to its FFY 1995 DSH payment adjustment expenditure patterns so that the State will not exceed its final FFY 1995 DSH allotment.

The FFY 1995 reconciliation of DSH allotments to actual expenditures will take place on an ongoing basis as States file expenditure reports with HCFA for DSH payment adjustment expenditures applicable to FFY 1995. In addition, any additional DSH payment adjustment expenditures made in succeeding FFYs that are applicable to FFY 1995 will continue to be reconciled back to each State's final FFY 1995 DSH allotment as additional expenditure reports are submitted to ensure that the final FFY 1995 DSH allotment is not exceeded. Any DSH payment adjustment expenditures in excess of the final DSH allotment will be disallowed.

Any DSH expenditures that are disallowed will be subject to the normal Medicaid disallowance procedures.

III. Preliminary FFY 1995 DSH Allotments Under Public Law 102–234

KEY TO CHART

Column		Description
Column A	=	Name of State.
Column B	=	Final FFY 1994 DSH Allotments For All States. For a high-DSH State, this is the State's base allotment which is the greater of the State's FFY 1992 allowable DSH payment adjustment expenditures applicable to FFY 1992, or $1,000,000. For a low-DSH State, this is equal to the final DSH allotment for FFY 1994 which was published in the **Federal Register** on May 2, 1994.

KEY TO CHART—CONTINUED

Column		Description
Column C	=	Growth Amounts For Low-DSH States. This is an increase in a low-DSH State's final FFY 1994 DSH allotment to the extent that the State's Medicaid program grew between FFY 1994 and FFY 1995.
Column D	=	Preliminary FFY 1995 State DSH Allotments. For high DSH States this is equal to the base allotment from column B. For low-DSH States, this is equal to the final State DSH allotments for FFY 1994 from column B plus the growth amounts from column C and the supplemental amounts, if any, from column D.
Column E	=	High or Low DSH State Designation. "High" indicates the State is a high-DSH State and a "Low" indicates the State is a low-DSH State.

PRELIMINARY FEDERAL FISCAL YEAR 1995 DISPROPORTIONATE SHARE HOSPITAL ALLOTMENTS UNDER PUBLIC LAW 102–234 AMOUNTS ARE STATE AND FEDERAL SHARES

[Dollars are in thousands(000)]

State	Final FFY 94 DSH allotments for all states	Growth amounts for low DSH states (1)	Preliminary FFY 95 state DSH allotments	High or low DSH state designation
A	B	C	D	E
AL	$417,458	NOT APPLICABLE	$417,458	HIGH.
AK	$19,589	$1,273	$20,862	LOW.
AR	$3,039	$203	$3,242	LOW
CA	$2,191,451	NOT APPLICABLE	$2,191,451	HIGH.
CO	$302,014	NOT APPLICABLE	$302,013	HIGH.
CT	$408,933	NOT APPLICABLE	$408,933	HIGH.
DE	$5,924	$1,063	$6,986	LOW.
DC	$41,039	NOT APPLICABLE	$41,039	LOW.
FL	$286,478	$76,223	$362,701	LOW.
GA	$382,344	$34,880	$417,224	LOW.
HI	$64,078	$3,887	$67,965	LOW.
ID	$1,985	$126	$2,111	LOW.
IL	$394,993	$69,434	$464,427	LOW.
IN	$336,799	$31,516	$368,315	LOW.
IA	$5,497	$689	$6,186	LOW.
KS	$188,935	NOT APPLICABLE	$188,935	HIGH.
KY	$264,289	NOT APPLICABLE	$264,289	HIGH.
LA	$1,217,636	NOT APPLICABLE	$1,217,636	HIGH.
ME	$165,317	NOT APPLICABLE	$165,317	HIGH.
MD	$129,543	$15,000	$144,543	LOW.
MA	$567,128	$19,052	$586,180	LOW.
MI	$617,700	$67,497	$685,197	LOW.
MN	$55,394	$5,225	$60,618	LOW.
MS	$158,464	$16,481	$174,946	LOW.
MO	$731,894	NOT APPLICABLE	$731,894	HIGH.
MT	$1,300	$78	$1,378	LOW.
NE(2)	$11,000	NOT APPLICABLE	$11,000	LOW.
NV	$73,560	NOT APPLICABLE	$73,560	HIGH.
NH	$392,006	NOT APPLICABLE	$392,006	HIGH.
NJ	$1,094,113	NOT APPLICABLE	$1,094,113	HIGH.
NM	$15,757	$1,743	$17,501	LOW.
NY	$2,831,864	$206,729	$3,038,594	LOW.
NC	$389,266	$49,413	$438,679	LOW.
ND	$1,155	$38	$1,193	LOW.
OH	$566,925	$73,044	$639,969	LOW.
OK	$23,568	$529	$24,097	LOW.
OR	$25,058	$5,537	$30,594	LOW.
PA	$967,407	NOT APPLICABLE	$967,407	HIGH.
RI	$94,432	$7,705	$102,137	LOW.
SC	$439,759	NOT APPLICABLE	$439,759	HIGH.
SD	$1,302	$137	$1,439	LOW.
TN	$430,611	NOT APPLICABLE	$430,611	HIGH.
TX	$1,513,029	NOT APPLICABLE	$1,513,029	HIGH.
UT	$5,514	$651	$6,165	LOW.
VT	$26,662	$1,351	$28,013	LOW.
VA	$185,746	$26,038	$211,785	LOW.
WA	$307,993	$33,210	$341,202	LOW.
WV	$121,883	$1,710	$123,592	LOW.
WI	$10,881	$1,978	$12,859	LOW.
WY	$1,389	$170	$1,559	LOW.
TOTAL	$18,490,099	$752,609	$19,242,708	.

PRELIMINARY FEDERAL FISCAL YEAR 1995 DISPROPORTIONATE SHARE HOSPITAL ALLOTMENTS UNDER PUBLIC LAW 102–234 AMOUNTS ARE STATE AND FEDERAL SHARES—Continued

[Dollars are in thousands(000)]

State	Final FFY 94 DSH allotments for all states	Growth amounts for low DSH states (1)	Preliminary FFY 95 state DSH allotments	High or low DSH state designation
A	B	C	D	E
NOTES:				

(1) There was 1 low DSH State which had negative growth and 7 low DSH States which got partial growth up to 12% of FFY 95 Map.
(2) Allotment based upon minimum payment adjustment amount.

IV. Regulatory Impact Statement

We generally prepare a regulatory flexibility analysis that is consistent with the Regulatory Flexibility Act (RFA) (5 U.S.C. 601 through 612), unless the Administrator certifies that a notice would not have a significant economic impact on a substantial number of small entities. For purposes of a RFA, States and individuals are not considered small entities. However, providers are considered small entities. Additionally, section 1102(b) of the Act requires the Secretary to prepare a regulatory impact analysis if a notice may have a significant impact on the operations of a substantial number of small rural hospitals. Such an analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 50 beds.

This notice does not contain rules; rather, it reflects the DSH allotments for each State as determined in accordance with §§ 447.297 through 447.299.

We have discussed the method of calculating the preliminary FFY 1995 national aggregate DSH target and the preliminary FFY 1995 individual State DSH allotments in the previous sections of this preamble. These calculations should have a positive impact on payments to DSHs. Allotments will not be reduced for high-DSH States since we are now interpreting the 12-percent limit as a target. Low-DSH States will get their base allotments plus their growth amounts.

In accordance with the provisions of Executive Order 12866, this notice was reviewed by the Office of Management and Budget.

(Catalog of Federal Assistance Program No. 93.778, Medical Assistance Program)

Dated: October 28, 1994.

Bruce C. Vladeck,

Administrator, Health Care Financing Administration.

Dated: November 16, 1994.

Donna E. Shalala,

Secretary.

[FR Doc. 95–850 Filed 1–12–95; 8:45 am]

BILLING CODE 4120–01–P

Social Security Administration

Agency Forms Submitted to the Office of Management and Budget for Clearance

Normally on Fridays, the Social Security Administration publishes a list of information collection packages that have been submitted to the Office of Management and Budget (OMB) for clearance in compliance with Public Law 96–511, The Paperwork Reduction Act. The following clearance packages have been submitted to OMB since the last list was published in the Federal Register on Friday, November 25, 1994.

(Call Reports Clearance Officer on (410) 965–4142 for copies of package.)

1. Supplemental Security Income Notice of Interim Assistance Reimbursement (TWO FORMS)—0960–NEW. Forms SSA–8125 and SSA–L8125 will collect interim assistance reimbursement (IAR) information from States which provide such reimbursement. Form SSA–8125 will be used in most cases. The use of form SSA–L8125 will be limited to situations where a person is collecting Supplemental Security Income payments because of disability due to drug abuse or alcoholism. The respondents will be States who provide IAR.

Number of Respondents: 140,000.
Frequency of Response: 1.
Average Burden Per Response: 10 minutes.
Estimated Annual Burden: 23,333 hours.

2. Pre-1957 Military Service Federal Benefit Questionnaire—0960–0120. The information on form SSA–2512 is used by the Social Security Administration to establish whether the wage earner's military service may be used to determine entitlement to or the amount of any Social Security benefit payable. The respondents are claimants who are applying for Social Security benefits on a record where the wage earner has pre-1957 military service.

Number of Respondents: 56,000.
Frequency of Response: 1.
Average Burden Per Response: 10 minutes.
Estimated Annual Burden: 9,333 hours.

3. Reconsideration Report for Disability Cessation—0960–0350. The information on form SSA–782 is used by the Social Security Administration to obtain additional information and evidence to support requests for reconsideration. The respondents are claimants under Title II and Title XVI of the Social Security Act who file a request for reconsideration of disability benefits.

Number of Respondents: 11,550.
Frequency of Response: 1.
Average Burden Per Response: 30 minutes.
Estimated Annual Burden: 5,775 hours.

OMB Desk Officer: Laura Oliven.

Written comments and recommendations regarding these information collections should be sent directly to the appropriate OMB Desk Officer designated above at the following address: Office of Management and Budget, OIRA, New Executive Office Building, Room 10230, Washington, D.C. 20503.

Dated: January 9, 1995.

Charlotte Whitenight,

Reports Clearance Officer, Social Security Administration.

[FR Doc. 95–924 Filed 1–12–95; 8:45 am]

BILLING CODE 4190–29–P–M

Mr. SABO. OK. Let me go quickly to another question. On page 28, I am trying to figure out the proportions of charts. I have an easier time with graphs than charts. As I look at that, it looks to me like acute care is growing more rapidly than the escalation of long-term care.

Ms. O'NEILL. Yes, that is true.

Mr. SABO. I wonder about that because the largest expenditures in Medicaid, not in terms of recipients but in terms of dollars, are long-term care; is that right?

Ms. O'NEILL. Yes. The cost per recipient for long-term care is many times greater than it is for the average person who receives acute care services. But the expansion of the program has been in terms of recipients who get acute care services. The children, pregnant women, and most of the disabled are receiving acute care services. They are not in institutions.

Mr. SABO. The reason I ask is sort of instinct would have told me maybe the opposite with more and more people getting to be 85 and older. There appears to be more of leveling off on long-term care than on acute care.

Ms. O'NEILL. It is still increasing. It is not that it has leveled off. It is still increasing.

Mr. SABO. No, but it is increasing slower than——

Ms. O'NEILL. It is only in comparison to the other. I think that is what you are really seeing there.

Mr. SABO. And the acute care is escalating because of increased caseload?

Ms. O'NEILL. I believe that the increase in acute care is largely due to the increase in beneficiaries who would receive these standard medical services. Some may be high-priced services. Disabled recipients are expensive to treat.

Mr. SABO. So it is basically——

Ms. O'NEILL. But they are not, by and large, in institutions.

Mr. SABO. It is basically an increase for people who meet the income eligibility.

Ms. O'NEILL. Right.

Mr. SABO. As I recall, the various eligibility rules for seniors, if they are below certain income levels, we pay the Medicare supplemental for them, do we not, or the deductible?

Ms. O'NEILL. Yes, that is true.

Mr. SABO. Do you know if that number is increasing?

Ms. O'NEILL. Yes, it is.

Mr. SABO. And then for others it reflects the growth in numbers that are eligibility for disability cash benefits and then for children those eligible for cash benefits plus those under the poverty line who may not receive cash benefits.

Ms. O'NEILL. Plus additional groups that don't receive cash benefits who have been coming in with expanded income eligibility criteria. That varies from State to State, but some States——

Mr. SABO. Is that the fastest-growing element, do you know?

Ms. O'NEILL. In the beneficiary population, that element has been increasing more rapidly than the cash beneficiaries.

The cash beneficiaries also increased rapidly between 1988 and 1993 because enrollment in the AFDC and the SSI programs took off. That generated additional people coming on to Medicaid from

the traditional populations. On top of that, though, the noncash benefit recipients came in because the definitions of who could be covered expanded.

Among those who are poor but not receiving cash benefits, eligibility can go up to 185 percent of the poverty line for some infants and pregnant women, and States have asked for waivers expanding it beyond that. A few States have asked for waivers that would expand their eligible groups to 300 percent of the poverty line.

Mr. SABO. Mr. Chairman, I have lots of other questions, but lots of other members are waiting.

Mr. KOLBE. Thank you, Mr. Sabo.

Mr. Smith of Michigan.

Mr. SMITH OF MICHIGAN. Thank you, Mr. Chairman.

Has CBO made any estimates on fraud?

Ms. O'NEILL. No, we haven't dealt explicitly with fraud.

Mr. SMITH OF MICHIGAN. So we don't have any idea of the cost of the fraud and misrepresentation, either by the providers or the recipients?

Ms. O'NEILL. No, we haven't. We don't have that capacity.

Mr. SMITH OF MICHIGAN. So does that mean you haven't reviewed the inspector general's or the FBI's fraud?

Ms. O'NEILL. The materials that we look at are the ones that are primarily related to cost increases and our ability to project cost increases. The component of fraud is difficult to incorporate into a cost estimate, and so we really haven't dealt with it.

Mr. SMITH OF MICHIGAN. Are there any regional differences in costs, either regional differences or urban/rural differences?

Ms. O'NEILL. There is wide variation from State to State, and some of it is also regional. The Northeast appears to have higher expenditures per capita or per beneficiary than other parts of the country. But there is a great deal of variation.

If you turn to the appendix in the prepared testimony—Tables A–1 and A–2—you will see the variation among the States. Although Medicaid is tied to poor populations in the example that I mentioned, if you compare New York and California, the difference is very striking. California has many more poor people, but its total expenditures on Medicaid are lower than in New York State. So there are differences which can be traced to causes; some of it has to do with the composition of the beneficiary population, some of it has to do with the size of the beneficiary population. Some of it has to do with variation in provider costs; some of it has to do with differences in the way States run things, how generous they are, how strict they are in enforcing various kinds of eligibility.

Certainly, DSH payments were made, as I understand it, largely under the law, but when you read about it, it looks like a scam. Nevertheless, it is something that wouldn't ordinarily come under your fraud example. DSH payments vary a lot from State to State.

Mr. SMITH OF MICHIGAN. Apparently, DSH payments are increasing; is that correct?

Ms. O'NEILL. Yes, they were increasing. They have slowed down recently, but increased hugely from—we don't have a very good measure of how much it was in 1988. It seemed to be about $1 billion. But that amount increased to $17 billion by 1993.

Mr. SMITH OF MICHIGAN. So how many States are getting DSH payments now?

Ms. O'NEILL. Nearly all States get some DSH payments, but——

Mr. SMITH OF MICHIGAN. And so the DSH payment——

Ms. O'NEILL [continuing]. Proportionately, some of them get little and some get a lot.

Mr. SMITH OF MICHIGAN. It seems to me if you make DSH payments to more and more hospitals, then it becomes less disproportionate.

Ms. O'NEILL. I think that over time what started out as being a payment that went into——

Mr. SMITH OF MICHIGAN. I am sorry. I want to get one last question in. Have you evaluated the increased cost of the program to find out how much of that goes to better treatment and how much goes to an expanded population?

Ms. O'NEILL. If better treatment is reflected in costs per person enrolled, we have that measure. In fact, the expenditures per recipient may not really be a very good measure of the quality of services rendered. The difference could be caused by inefficiencies. It could be caused by inflationary differences in prices.

Mr. SMITH OF MICHIGAN. I think your answer was "no."

Ms. O'NEILL. Right.

Mr. SMITH OF MICHIGAN. So technology hasn't been considered as far as the increased quality of service?

Ms. O'NEILL. It is included, but is in the component of costs per beneficiary.

Mr. SMITH OF MICHIGAN. Thank you.

Mr. KOLBE. The time of the gentleman has expired.

Mr. Pomeroy is next.

Mr. POMEROY. Thank you, Mr. Chairman.

Thank you for your testimony, Dr. O'Neill. The question I have relates to some of the discussion about the block grant reforms that I think we will be seeing proposed for the Medicaid program.

On page 18, you note that part of the expansion occurring in the third period of time you traced was due to the recession and its resulting impact on the number of families enrolling in the program. Is there a provision in a block grant concept to allow program expansion in a period of economic downturn which would result in more families being unemployed and qualifying for eligibility?

Ms. O'NEILL. There are many ways that one can design a block grant, but, there could be some provision made for recession-related changes, which had to do with the growth in the AFDC caseload. Both the AFDC and the SSI caseload respond to increases in unemployment. More people go on cash benefits, and they automatically qualify for Medicaid.

Because there are more poor people during a recession, trigger mechanisms could be included to respond on a discretionary basis. There are many ways in which one could take account. For example, the unemployment insurance program is not a block grant, but it is a State-Federal shared program that has triggers; when unemployment goes up in a particular State, extensions of benefits are triggered.

Mr. POMEROY. Dr. O'Neill, you are familiar with the most recently passed block grant reforms enacted by the House, those to

the nutrition programs as part of the welfare reform debate. Did those block grant proposals have any expansion character to deal with the event of national recession?

Ms. O'NEILL. They had a $1 billion rainy day fund. There is nothing to prevent a State from setting up an additional rainy day fund. States could have some kind of small tax——

Mr. POMEROY. With Federal dollars?

Ms. O'NEILL. Pardon?

Mr. POMEROY. With Federal dollars?

Ms. O'NEILL. No. They can do this on their own.

Mr. POMEROY. Correct, there is no—right.

Ms. O'NEILL. In addition to the reliance on Federal——

Mr. POMEROY. So those block grant——

Ms. O'NEILL. Their own insurance system.

Mr. POMEROY. Those most recently enacted—if we are going to talk about a block grant, sure, you can draw them how you want to, although the most recent one drawn and passed by the House did not allow for expansion in time of recession, it seems to me.

Now, moving to another component of a block grant formula, if it is based in any respect on past formulas, past payments to States, it seems that that would reward those States that have been most adept at gaming the system. In fact, your testimony points out that the variance between States deals with more than the qualifying populations; it is how effectively the States have gamed the Medicaid system. In fact, on page 9——

Ms. O'NEILL. In part, that is certainly true.

Mr. POMEROY. On page 9, you note that, therefore, moving to a block grant based on formulas would seem to reward the good citizens. I represent North Dakota. I think we have been good citizens out there. We have not resorted to elaborate ways to access the Medicaid program to assist the State budget. We have pretty much played by the rules.

Now, if you move right to a block grant based on past payment practice, it seems like we get hit.

Ms. O'NEILL. If it was frozen today, that would be true, but there is no reason that one would necessarily fix today's allocation in stone. There are certainly a large number of ways to accomplish——

Mr. POMEROY. You would suggest adjusting—if you do deal with a formula, a formula based merely on past payout, you are suggesting, wouldn't be equitable in light of the variations across the country with how States have accessed the Medicaid funds?

Ms. O'NEILL. Equity, I suppose, is in the eye of the beholder, but it would certainly be prudent to take a look at some of the changes that occurred in the past few years, particularly in trying to set forth some allocation formula for a block grant.

Mr. POMEROY. Thank you very much.

Thank you, Mr. Chairman.

Mr. KOLBE. Next, if his voice can hold out here, is Mr. Bass from New Hampshire.

Mr. BASS. Thank you very much. As you can tell, I have laryngitis, and my questions will be short.

Continuing on with Mr. Pomeroy's line of questions, I am wondering whether or not you might be able to provide this committee

with some sort of a meaningful table which we rank or list States that have received DSH payments as a percentage of something, maybe the number of recipients or total number of dollars over time other something, so that we could tell or quantify that disproportionality that may or may not exist?

And my second question to you, Dr. O'Neill, so I do not have to speak again, I wonder if you could comment on the impact that revising the eligibility requirements for SSI, most notably, for example, having a periodic reapplication process or changing the definition of mental disability or some other mechanism would have on future payments of Medicaid, not only the State share, but the Federal share?

Ms. O'NEILL. To answer your first question, we could do that for the record: supply a list of States with their DSH payments as a percentage of Medicaid expenditures.

[The information requested follows:

In response to your request, we are including a table in the record that shows States' disproportionate share payments as a percentage of their Medicaid expenditures. The table was taken from a recent publication put out by the Urban Institute. (See Colin Winterbottom, David W. Liska, and Karen M. Obermaier, "State-Level Databook on Health Care Access and Financing," Washington, DC: the Urban Institute, 1995.)

Medicaid Expenditures by Service:
Disproportionate Share Payments, 1992-93

(Expenditures in millions)

	1992		1993					
	Total DSH		Total DSH		Inpatient DSH		Mental Health DSH	
	DSH[20]	Percent of Total Expend.	DSH	Percent of Total Expend.	DSH	Percent of Inp. Expend.	DSH	Percent of MH Expend.
United States	**$17,525.6**	**15.3%**	**$16,944.0**	**13.5%**	**$14,400.4**	**36.1%**	**$2,543.6**	**55.0%**
New England	**$1,488.0**	**17.4%**	**$1,564.6**	**17.3%**	**$1,181.7**	**47.6%**	**$382.9**	**80.3%**
Connecticut	395.1	18.3	417.3	18.3	269.3	52.3	148.0	80.1
Maine	139.2	19.2	164.1	19.3	121.2	53.0	42.9	74.4
Massachusetts	457.3	11.8	484.5	12.0	324.1	30.8	160.4	86.8
New Hampshire	392.0	54.2	382.9	50.2	360.5	93.0	22.4	72.0
Rhode Island	81.3	10.5	97.2	11.7	97.1	37.4	0.1	0.9
Vermont	23.1	9.2	18.6	7.3	9.5	23.1	9.1	93.4
Middle Atlantic	**$5,180.9**	**16.4%**	**$4,458.1**	**14.9%**	**$3,325.2**	**37.6%**	**$1,132.9**	**57.3%**
New Jersey	1,094.1	24.3	1,088.2	23.1	769.7	44.1	318.6	82.8
New York	3,119.4	14.8	2,558.7	13.0	2,224.8	37.2	333.9	40.8
Pennsylvania	967.4	15.7	811.1	14.5	330.7	29.5	480.5	62.1
South Atlantic	**$1,642.2**	**10.5%**	**$1,700.6**	**9.3%**	**$1,191.5**	**22.6%**	**$509.1**	**66.6%**
Delaware	0.0	2.2	5.2	2.1	0.0	0.0	5.2	77.0
District of Columbia	32.9	5.6	46.1	6.7	32.1	13.0	14.0	24.8
Florida	191.4	4.7	239.7	4.8	175.7	13.7	64.0	81.6
Georgia	300.5	12.3	309.4	11.1	309.4	31.2	0.0	0.0
Maryland	113.0	5.8	77.8	4.0	22.9	3.5	55.0	83.0
North Carolina	332.4	13.7	345.5	11.9	13.2	2.3	332.3	90.8
South Carolina	439.8	29.3	440.7	26.2	412.5	58.4	28.2	41.8
Virginia	147.8	9.4	130.8	7.3	120.3	25.2	10.4	11.3
West Virginia	84.4	9.1	105.3	8.8	105.3	36.6	0.0	0.0
East South Central	**$1,265.7**	**18.8%**	**$1,138.7**	**15.4%**	**$1,135.4**	**45.0%**	**$3.3**	**2.9%**
Alabama	417.5	27.8	419.1	25.6	419.0	63.7	0.1	0.5
Kentucky	264.3	14.6	137.0	7.4	137.0	28.6	0.0	0.0
Mississippi	153.3	14.3	152.3	12.7	152.3	36.8	0.0	0.0
Tennessee	430.6	18.3	430.2	16.1	427.1	44.0	3.2	7.2
West South Central	**$2,755.5**	**24.2%**	**$2,756.7**	**21.3%**	**$2,724.9**	**50.1%**	**$31.8**	**19.0%**
Arkansas	2.5	0.3	2.5	0.2	2.5	1.2	0.0	0.0
Louisiana	1,217.6	36.6	1,217.6	32.6	1,190.7	63.8	27.0	39.5
Oklahoma	22.3	2.2	23.5	2.2	18.6	7.3	4.8	9.1
Texas	1,513.0	24.9	1,513.0	21.3	1,513.0	48.7	0.0	0.0
East North Central	**$1,330.2**	**9.0%**	**$1,275.2**	**6.6%**	**$1,208.6**	**22.0%**	**$66.6**	**15.5%**
Illinois	313.8	7.5	240.1	4.8	240.1	12.4	0.0	0.0
Indiana	211.6	9.5	33.8	1.2	24.9	4.9	8.9	16.9
Michigan	544.3	14.3	544.7	12.5	488.5	37.6	56.3	29.6
Ohio	451.8	9.5	449.0	8.7	449.0	30.0	0.0	0.0
Wisconsin	8.7	0.4	7.6	0.4	6.1	2.4	1.5	4.1
West North Central	**$970.6**	**13.9%**	**$927.1**	**12.5%**	**$599.2**	**35.2%**	**$327.9**	**74.4%**
Iowa	4.6	0.5	4.0	0.4	4.0	2.0	0.0	0.0
Kansas	188.9	20.7	184.4	20.7	4.4	3.1	180.0	86.3
Minnesota	42.0	2.2	32.3	1.5	24.6	9.4	7.7	19.5
Missouri	731.9	31.7	703.1	31.2	564.0	64.1	139.0	91.8
Nebraska	3.1	0.7	3.3	0.6	2.2	1.9	1.2	9.7
North Dakota	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
South Dakota	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Mountain	**$212.4**	**13.4%**	**$225.7**	**6.8%**	**$223.4**	**22.6%**	**$2.3**	**2.5%**
Arizona	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Colorado	120.8	30.6	130.5	12.0	129.6	32.7	0.9	4.0
Idaho	1.4	0.5	1.0	0.3	1.0	1.7	0.0	0.0
Montana	0.1	0.0	0.5	0.2	0.1	0.1	0.5	2.3
Nevada	73.6	20.3	80.3	19.0	80.3	45.8	0.0	0.0
New Mexico	11.8	2.3	8.8	1.5	8.8	5.9	0.0	0.0
Utah	4.5	1.1	4.5	0.9	3.6	2.8	0.9	11.0
Wyoming	0.1	0.1	0.1	0.1	0.1	0.3	0.0	0.0
Pacific	**$2,480.0**	**16.6%**	**$2,897.4**	**16.6%**	**$2,810.6**	**39.2%**	**$86.8**	**54.5%**
Alaska	0.0	7.9	33.3	12.4	0.0	0.0	33.3	97.2
California	2,191.5	18.8	2,542.5	18.8	2,542.5	40.2	0.0	0.0
Hawaii	40.4	11.8	43.9	11.5	43.9	33.7	0.0	0.0
Oregon	17.3	2.2	20.6	2.2	10.3	7.5	10.3	37.1
Washington	230.9	11.5	257.0	11.1	213.9	39.6	43.2	44.5

Source: Health Care Financing Administration Form 64.
Note: See table notes for Section D.

To answer the second question, the definition of disability—and I believe this is true for any disability program that we have had, whether it is Medicaid, SSI, or it is Old-Age, Survivors, and Disability Insurance [OASDI]—it is always very tricky to define what disability is and to interpret it, because there is always some margin; it is not always a clearcut phenomenon.

At the Federal level, there are guidelines. Probably they could be tightened. States, however, have interpreted disability more loosely or more strictly. Different States have approached it differently.

Mr. BASS. No further questions, Mr. Chairman.

Mr. KOLBE. Thank you very much, Mr. Bass.

Next is Mr. Orton.

Mr. ORTON. Thank you, Mr. Chairman and Dr. O'Neill. Welcome, and I appreciate your testimony.

In the short period of time that I have to ask a question, I would like to focus somewhat narrowly in a targeted area. I have a number of questions as to how we may tighten the Medicaid system so that the payments and benefits are actually going to those who need it the worst, eliminating abuse, et cetera.

I would like to focus on the one area of long-term care for the elderly. Do your records indicate what percentage of the growth in Medicaid costs have been attributed to the increase in long-term care and whether that is an increase in patient load or an increase in costs per existing patients?

Ms. O'NEILL. In the period of rapid growth from 1988 to 1993, the proportion of Medicaid expenditures accounted for by the elderly, who are the major users of long-term care, actually declined a little bit. The elderly accounted for 35 percent of Medicaid expenditures in 1988, and that fell to 31 percent in 1993.

That does not mean that expenditures were declining. Care of the elderly just was not increasing as fast.

That can also be seen on the chart that shows the increase in the acute care rising more rapidly than that of long-term care.

Mr. ORTON. I thought in your testimony you had reflected——

Ms. O'NEILL. We have projected that the Federal share of payments for long-term care would increase from $32 billion in 1995 to nearly $52 billion by the year 2000.

Mr. ORTON. So it is a significant portion of the projected growth.

Ms. O'NEILL. Yes, it is still significant. And even though the number of elderly recipients have not been the most rapidly growing part of the Medicaid program, they generate very high expenditures for obvious reasons. In large part, they do so because they are much more likely than other people to be in long-term care.

Mr. ORTON. One area which could be viewed as an abuse, which I personally witnessed as a lawyer in private practice, a number of clients wanting to plan for their estates and wanting to transfer property to their children, much of the incentive was to get property transferred out of their estate prior to becoming ill, so that if they went into a long-term care facility, it would not deplete the estate to pay the long-term care costs. You could transfer the property to the family or the children, afterwards going on Medicaid so the government would pick up the tab for the long-term care.

From my perspective and what I have seen, that is a fairly common practice. I am wondering if we have done any analysis of that and whether you have looked at any options.

That is certainly one of the areas that I have been looking at, is some way to limit that type of abuse, so that—and, by the way, it is usually the children of those parents who have received the assets, then putting their parents on Medicaid, who are crying the loudest about cutting their taxes and reducing Federal spending.

Ms. O'NEILL. Everybody knows anecdotally about at least one instance of that problem. But statistically it is very hard to pin down. I do not think we have a count of the proportion of people in nurs-

ing homes who had divested themselves of their estates and then fallen back on Medicaid.

Some authors have suggested that stricter regulation of transfers could yield considerable savings. In an article in the National Journal Steve Moses suggested that stricter regulation could save $25 billion over a 5-year period.

But that is very hard to verify. And in 1993, we did close many of the asset-transfer loopholes, so that now it is up to the States to enforce those regulations. So again, we are back to the States and State discretion in carrying out many of the provisions of Medicaid.

Mr. ORTON. Thank you, Dr. O'Neill. Thank you, Mr. Chairman.

Mr. KOLBE. Thank you, Mr. Orton.

We are pleased to welcome to our midst here today a Member not of the Budget Committee, but one of our House doctors, Dr. Ganske, and would like to invite him to ask questions, if you would like.

Dr. Ganske.

Dr. GANSKE. Thank you, Mr. Chairman. I think I will just follow up a little bit with what Mr. Pomeroy was saying, and maybe there is something about the Midwest, but my home State of Iowa has been either less than smart in not getting too involved with the DSH payments or maybe more honest.

I guess I would share his concern that if, in fact, at some time in the future we are talking about block grants that we take into consideration the fact that some States have not gamed the system.

But I wonder if we could just go to page 3 of your testimony. In looking at the chart you have projected big, rapid increases.

Just for my own benefit, when you make these projections, how do you take into account unemployment and economic projections or predictions?

Ms. O'NEILL. When we do projections, we look at the different beneficiary populations. That comes into play because many Medicaid beneficiaries are recipients or part of families that receive AFDC payments, and AFDC is a sensitive program. So in that way, more people would be coming onto the program.

CBO studies these programs using past experience as a guide to what will happen to the future, so we know the sensitivity of the cash welfare programs or recipients in the cash welfare programs to changes in unemployment. In that way unemployment gets factored in, because we have projections for increases in the AFDC population and the SSI population.

Dr. GANSKE. So are you predicting an economically future, or——

Ms. O'NEILL. No. We do the projection twice a year and we revise our macroeconomic forecast and assumptions for the next 5 years. Of course, you know nobody can——

Dr. GANSKE. Sort of hit-and-miss.

Ms. O'NEILL. Can hit it right.

Dr. GANSKE. Let us go to page 8. The thing that strikes me most about your chart here in comparing 1988 to 1993 is the shift in hospital versus nursing home percentage.

Ms. O'NEILL. Right.

Dr. GANSKE. Hospital has gone up; nursing home has gone down.

Can you explain that? And is the change in SNF units or skilled nursing facilities being taken up by hospitals part of that explanation?

Ms. O'NEILL. Actually, the biggest part of that explanation is again the DSH payments, because they are included as part of hospital costs. So to some extent, it may not be important that hospital expenditures were rising more rapidly. DSH payments are included in the hospital share, and that is what is creating the appearance of an increase in hospital expenditures that may not be entirely there.

Dr. GANSKE. OK. How about page 11? Let us look at your chart there.

The big increase that I see there from 1988 to 1993 is in children. Now I assume that the 18 percent in 1993 for children does not include disabled children; for example, those children that may have behaviorally dysfunctional disabilities. Is that right or not?

[Pause.]

Ms. O'NEILL. You are right. Those children are included under "disabled," not in "children."

Dr. GANSKE. Is the increase in "children" due to increasingly expensive treatments for a subpopulation; for instance, babies with AIDS in neonatal ICU's?

Ms. O'NEILL. Actually it is caused by the expansion in the number of children—the largest component of the increase in the number of Medicaid beneficiaries. They include children who are poor and not in families receiving cash benefits, as well as those who are in families with income levels above the poverty level, up to 133 percent in some instances and up to 185 percent of the poverty level in others.

So a wave of poor and near-poor children was really added to the program, and that is primarily what is reflected, rather than an increase in the expenditure per child.

Dr. GANSKE. Thank you. Thank you, Mr. Chairman.

Mr. KOLBE. Thank you, Dr. Ganske.

We have time to get at least one more person in questioning. Mrs. Meek is next.

Mrs. MEEK. Thank you, Dr. O'Neill. I appreciate——

Mr. KOLBE. Excuse me. Our machine is on kaput here, so we will use a stopwatch or a timer here, our own timing device.

Go ahead, Mrs. Meek.

Mrs. MEEK. Thank you, Dr. O'Neill, and I appreciate your appearance before us this morning.

I am from Florida and served in the State Legislature there for many years. I saw what happened many times with disproportionate share, with big public hospitals like Jackson Memorial—I am sure are you familiar with that—and we have been discussing recently a national cap in Medicaid.

But I do not think that we are taking into consideration such dynamics or variables as population growth and changes in ages.

As you know, our problem in Florida is not so much the changes in population as changes in age. People are getting to be 85 years or older in Miami and in Florida, and it will make a distinct difference when we do the kind of reform which I think we shall.

How do you, as someone who is—you know, seeing the view from Pompeii's head—how do you figure what can happen in terms of factoring in some adjustment for these variables for States like Florida and growing States like my friend, Representative Allard represents the State of California. How can you adjust for those factors on an individual State basis and not just have a cookie-cutter approach to this?

Ms. O'NEILL. I do not think that anybody would actually recommend a cookie-cutter approach. Certainly the current level of Medicaid expenditures varies from State to State, in large part because of such reasons as the ones you mentioned. Florida, you would anticipate, would be an above-average Medicaid State because it has a larger older population than most States.

Other States happen to have a large percentage of people with AIDS, which would be another reason for a State to have higher Medicaid expenditures.

Mrs. MEEK. How do you adjust a national cap to take this into consideration?

Ms. O'NEILL. There are various ways of doing it. If you use the current differences among the States, Medicaid payments are accounted for to a large extent by demographic factors such as the percentage of aged and disabled, as well as differences in income level. States that have a larger-than-average poor population are also going to have more people in the Medicaid program.

But there are also variations because of increases in costs, and some of that is just because of differences in prices. Some States are more expensive to live in than other States. Some of it may have to do with quality. Some States may have more technology, more kinds of high-quality services.

So all of these factors contribute. Now the allocation of a Medicaid block grant would be a matter for Congress to decide. If you went to something like a block grant, what factors would you take into account? Would you modify the existing distribution of Medicaid expenditures based on population differences?

That would be an issue to be decided. Certainly an important one.

Mrs. MEEK. Thank you.

Mr. KOLBE. I think we will take a break right here, because I do not think we will have time to get through one more full line of questioning. And Dr. O'Neill will resume as soon as we come back from voting on the journal here. We will return right away. I hope members will come back, so they can resume the questioning.

Thank you. The committee will stand in recess.

[Recess.]

Mr. MILLER [presiding]. May I have your attention? Mr. Kolbe will be back in a few minutes. He had a TV interview, and then he will be back. But he asked me to continue with the hearings.

And Mr. Stenholm from Texas is next. Mr. Stenholm.

Mr. STENHOLM. Dr. O'Neill, listening to your answers to previous questions and looking through not only your testimony but that of everyone else, I believe there is no mention of the efficiency or the lack thereof of administration of the Medicaid program.

According to a figure that I have, in 1995 we will spend 3.4 percent of the Medicaid total payments on administration. The States match that with another 3.4; that is 6.8 percent.

Is there anything that you might share with us that would suggest that in administering the Medicaid program we are or are not as efficient as we should be?

Ms. O'NEILL. Again, since Medicaid is essentially State-run, it is extremely difficult to make determinations in a broad way. I am sure there is always room for more efficient administration. But efficiency could affect not only administration but the extent to which States are strict in enforcing various kinds of eligibility standards and the kinds of things that they pay for. So there are many ways that a State could be more or less efficient.

But the data that we have to go on are really very slim. The reporting is fairly skimpy; at least the data that we have been able to obtain don't provide a lot of answers to basic questions. We know very little about the details of the Medicaid program as it is conducted in all of the different States.

Mr. STENHOLM. Along that line, when I look at a chart that we have been provided by GAO and we look at the Medicaid expenditure by States for the fiscal year 1993, I see a range of spending per Medicare recipient that goes from a low of $2,372 to a high of $5,930. Why should I not have a little bit of concern about a total block granting of a program when we enter into it with that much disparity already evident within States.

Ms. O'NEILL. I think it would be important to know what the sources of the variation would be among the States. In part, the sources vary because of demographic factors, differences in the percentage of elderly, differences in disabled, the incidence of disability, and differences in income levels that may bring people with more severe kinds of medical problems on to the——

Mr. STENHOLM. Could you quantify what percent of it would be demographic?

Ms. O'NEILL. We haven't really done an analysis of that sort among the States. It would be difficult to do because you would have to gather all of this type of data for the different States.

Some of the variation is also caused by differences in the use of medical technology among the States as well as differences in costs. Nurses and doctors are paid more in some States than in others. Some of that may be related to quality, but some of it may be just a pure price difference.

The benefit package that is provided in different States also varies. Some have used the optional services and have a broader array of services than other States. All of these factors would be important.

Of course, the DSH payments are another story because that has added another layer of differences among the States. Some States have been much quicker to take advantage of those than others, as we have heard.

Mr. STENHOLM. I thought the charts on pages 8 and 11 of your testimony were particularly interesting in seeing that since 1988 the changes that were occurring and the area that is going up was hospital care; nursing home is going down.

Ms. O'NEILL. Nursing home care is going down proportionately, and that is in large part because DSH payments are counted in with hospital care, but they aren't actual hospital services.

Mr. STENHOLM. So the DSH payment have an effect on that proportion.

Ms. O'NEILL. Yes, because they are counted, and that is a big block of expenditures.

Mr. STENHOLM. Thank you.

Mr. MILLER. Mr. Herger.

Mr. HERGER. Thank you very much, Mr. Chairman.

Director O'Neill, it is great to have you with us. If you could tell me, if you would, why Medicaid has been unable to achieve the cost reductions similar to those experienced by the California Public Retirement System which reported reductions of HMO premiums of 0.4 percent in 1993–94, 0.7 percent reduction in 1994–95, and a 5.2 percent for 1995–96.

Ms. O'NEILL. In part, it is difficult to make that comparison because we are talking about total expenditures when we are talking about Medicaid, not a premium component. Something similar has also happened in private insurance in the country as a whole; premiums have increased slowly or even declined, according to some surveys in the past year.

When we talk about Medicaid expenditures, we are not talking about a fixed population of people. We are talking about a population that was changing in composition as well as in numbers from year to year, so that growth reflects both increases in number of persons receiving services and costs per beneficiary.

In addition to that, as relatively more disabled were added to the Medicaid rolls, there was a compositional change that generated an increase in the average expenditure per recipient. So the comparison isn't really a straightforward one. It is not really apples and apples.

That is not to say that Medicaid is a program that has had low growth, because even if you look within, there has been growth in expenditure for a fixed type of beneficiary. I don't know the exact amount, but I am sure that it is more than in the California program.

I think it is also true, even in the Federal employee program, that premium rates have gone up, much more slowly than would be the case in the Medicaid or the Medicare programs, both of which grow quite rapidly.

Mr. HERGER. Has the cost of disabled gone up equivalent?

Ms. O'NEILL. The cost per disabled person?

Mr. HERGER. Yes.

Ms. O'NEILL. I don't know the exact amount, but I am sure it has been increasing, and probably faster than inflation. It would certainly be increasing more than the standard premium.

Some of that increase may be caused by the types of disabilities that are more expensive to treat and some of it may be caused just by the characteristics of the Medicaid program.

Mr. HERGER. Well, I guess the concern is—you mentioned premiums. I have to assume that premiums are reflecting companies' costs, and, therefore, if those premiums are going down, those costs at least are not going up as rapidly as they thought. And I guess

the comparison and the concern is: Why do we have a government-run program that is escalating and continues to escalate with cost increases while the rest of medical costs seem to be more leveling off? I think that is the major question. There seems to be a very large difference between the two.

Could you also tell me how the rate of increase of outlays in Medicaid and Medicare compare? Does the explanation for the growth of Medicaid outlays differ from the explanation for the growth of Medicare outlays? If so, how?

Ms. O'NEILL. Medicaid has been growing more rapidly than Medicare in the 1988–1993 period. Assuming that the DSH payment problem is under control and that some of the cost savings that have been around in the private sector would begin to affect Medicaid as well, we are projecting a slower rate of growth over our 1995–2000 projection period than was true in the past. We are also projecting approximately the same growth in Medicare as in Medicaid over that period. Both will be lower than they have been and both will be approximately the same in our projections.

Mr. HERGER. Thank you.

Mr. MILLER. Ms. Roybal-Allard.

Ms. ROYBAL-ALLARD. Ms. O'Neill, I would like to follow up on Mrs. Meek's question with regard to the 5-percent cap. If I understand you correctly, you said that we needed to be cautious with a cookie-cutter approach to capping payments because we need to take into consideration the differences in the variation of States such as high growth versus low growth, and the efficiency of States at administering programs.

Has the CBO done an evaluation State by State as to what would be the impact on the States if a 5-percent Medicaid cap were enacted across the board without adjusting for State variations?

Ms. O'NEILL. No, we have not done such a study.

Ms. ROYBAL-ALLARD. Would it be possible for you to do such a study so that as we are moving forward with these proposals, we would have an idea as to how a 5-percent cap would impact, for example, California, the Southwest and Mountain regions which are considered high-growth regions?

Ms. O'NEILL. It is possible to do this. I think it is difficult. I am not sure whether we could do a reasonable job.

The Kaiser Commission did make a rough estimate of what a 5-percent growth cap would save. I believe they came up with something like $85 billion over a 5-year period.

Ms. ROYBAL-ALLARD. The information that I have is that the Kaiser Foundation found that in the year 2000 the reduction in Federal expenditures would range from 2.7 percent in New Hampshire to 27 percent in West Virginia, and in absolute dollars terms, and States that would be impacted most are New York, $8.9 billion; followed by California, $6.9 billion; and Texas, $5.4 billion. So a 5-percent cap, it appears to me, if it were done across the board without taking into consideration any variations in States, would actually punish high-growth States and States that, for whatever reason, are administering the Medicaid costs more efficiently.

Ms. O'NEILL. If all States were given a flat cap, there would obviously be other issues to consider. Sometimes a flat cap can be more unfair than one that is variable.

It is enormously difficult, though, to make estimates by State, just because of a lack of data. The data that are available on the Medicaid program on a State-by-State level are really not what one would need to make a very refined kind of estimate.

Ms. ROYBAL-ALLARD. But you would agree that there are variations in States, and some States would be more negatively impacted than others based on an across-the-board 5-percent cap without taking into consideration any variations?

Ms. O'NEILL. That would probably be true, but it depends on what causes the expenditures to vary. For example, if you include the DSH payments, and they are a source of variation in expenditures, the significance of that fact could depend on what the States were were doing with their DSH payments and what their real need was for those payments. You can't really assume that just because a State was growing very rapidly that it really needed to be doing so. That may be true in the case of some States. It wouldn't be true in the case of others.

Ms. ROYBAL-ALLARD. But in order to help States meet a need if it were to occur, assuming that everything else they were running efficiently and the States have no control over the growth factor and their need increased, once they reached whatever the 5-percent cap is, then chances are then States would have to start drawing from their own limited resources in order to meet the needs of the additional growth rate.

Ms. O'NEILL. I think it is very hard to make a blanket statement about what happens in the various States. But it is certainly not easy to devise a formula. Under the current system, however, it is not clear that everything is perfect. I am sure that many States feel that some of the rules are unfair to them, that they get penalized for things that they might want to do. There is never going to be any system that everybody agrees is totally fair to them.

Ms. ROYBAL-ALLARD. But if a 5-percent cap were put in place, there has to be some guidelines, something that you could provide to States so that they could prepare for unforeseen events. We can't just tell them, well, we are going to do a 5-percent cap and we don't know what the future holds, so good luck. Governors of the States and the State legislatures are still going to need to provide the services for people under the Medicaid program. For example, if growth like in California continues, Medicaid services will still need to be provided. So there has to be some flexibility, I would think, in terms of any proposal that we put forward.

Ms. O'NEILL. Of course, the growth in many States was voluntary. It happened because a particular State wanted to do something more than what other States were doing. So it is very mixed. In some it could be because of totally demographic factors, but in other States——

Ms. ROYBAL-ALLARD. But what would you do to address the need?

Ms. O'NEILL [continuing]. It isn't, so the sources of the growth would vary among the States. It is hard to account for every single individual variation among the different States.

Mr. MILLER. Thank you. Let me ask a couple questions, if I may, now. I am from Florida, which is a growth State like Mrs. Meek was asking about earlier, and I have concern about the formula. I

think we will continue to have that. It is not a very simple issue, as you are saying, and I know California has the same concern.

But the real issue is going to the concept of the block grants, and then how we divide up the block grant is the formula issue, and that is very critical, very important. But looking at it from the Federal Government perspective, going away from an entitlement type program to a block grant, what control does the Federal Government continue to have over total expenditures for health care and the advantage of that? I am not talking about the details of the formula, which I have serious concerns in Florida, but the idea of the block grant and the advantages of it to the State.

Ms. O'NEILL. Potentially the Federal Government would have much more control over its share of what it spends because that could then be determined. The Federal Government could then say, "This is what we have to spend, this is what we can afford," and then divvy it up amongst the States. So Federal control would actually be increased.

Right now a lot of Federal expenditures are reactive. Because the amount of the built-in Federal share is set, the proportion of total spending by the States that is the Federal share follows what the States spend. The Federal Government doesn't say, "We are just going to give you X dollars and no more." They say, "If you spend X dollars we will pay 50 percent, 60 percent, or whatever the Federal share is for a particular State.

So right now Federal control really is not that great. The Federal Government has certain rules, sort of rough guidelines for the States, but the States are really the ones who are calling the shots, and the Federal Government then pays up according to what States are spending. The States are really in the driver's seat. With block grants, that situation could be reversed. The Federal Government would say, "this is what we will give you," and then it would be up to the States to conserve. Presumably, one feature of such a plan would be that the States would then have to decide what to do above and beyond the routine that they would then have to pay for.

Mr. MILLER. So you are saying, actually, for the low-cost States and growth States, like Florida and California, where we have held our Medicaid costs under control as best we could, States that have very high Medicaid costs, if you look at Connecticut or New York, for example, which have a very high per capita cost, have allowed their costs to go out of sight, and we are the ones now—and I agree the concern about a 5-percent cap if it is hit across the board, 5 percent of $4,000 or 5 percent of $1,000 is not fair.

But you are saying probably by having the block grants we are going to be able to get better control over that rather than a total entitlement. Is that what you are saying?

Ms. O'NEILL. Yes. You would have more control over it. That is for sure.

I am glad I am not the one who has to determine whether there should be a block grant, and how it would be distributed among the States. It is certainly not going to be an easy job if that is the route that the Congress takes.

Mr. MILLER. Let me ask you one more question. The projections by the CBO versus OMB for Medicaid growth over the next 5

years—and it looks like OMB has got a more conservative projection—why is there a difference between OMB and CBO's estimates?

Ms. O'NEILL. I am not sure which one is more conservative. I think in a way——

Mr. MILLER. Less dollars, probably.

Ms. O'NEILL [continuing]. We consider ours more conservative because we weren't allowing for as large cutbacks as did OMB. OMB used the experience of 1994 when the growth rate in Medicaid expenditures was much lower than it had been. It was a little over 9 percent.

OMB assumed that would be true in the long run. We were unwilling to say that the rate of growth of Medicaid would actually be reduced that much. It had been growing at a rate of 16 percent a year. We are about 2 percentage points above the 1994 growth rate in terms of growth rates over the 5-year period of 1996–2000.

Mr. MILLER. Thank you.

Mrs. Mink.

Mrs. MINK. Thank you very much, Mr. Chairman.

I have never really understood why the Federal matching percentage varies from State to State. Your page 33 has this table showing the Federal contribution percentages for 1993: places like California at 50 percent; New York at 50 percent; my own State at 50 percent.

Could you explain why that percentage varies and how it would be affected if the proposals for block granting should go into effect, how that percentage column might vary?

Ms. O'NEILL. It varies now with per capita State income. Inversely, the higher a State's per capita income, the lower the Federal match. So a State like California that is one of the wealthiest States would have a lower match. A State with lower per capita income would have a higher match.

Mrs. MINK. So under the proposals for a block grant, would that differentiation between States still be maintained, or how would that proposal affect the distribution of Federal funds?

Ms. O'NEILL. As I see it, it wouldn't necessarily come out to be what the match is now, because the Federal share would be set. That share is likely to resemble to a large extent the pattern of expenditures by States. But the total spending could change because some States will probably go after cost-cutting more stringently than will others. So the total could fall or rise much more slowly in some States than in others because of the way the States choose to manage the program or set their goals in terms of eligibility.

Some States may choose to cover a wider proportion of the population, in which case their expenditures might rise. For that reason, the Federal component would decline. So the block grant approach is really saying how much the Federal Government is going to contribute, and that will presumably be related, like it is now, to per capita income of the States. You would still expect that some States will get disproportionately more from the Federal Government because they have a lower income level.

Mrs. MINK. There is always enormous interest in the committee on the projections of costs by the CBO in terms of some of these very large expenditures, and, of course, the expenditures in Medic-

aid are not an exception. We are very interested in the projections of total costs.

In your last couple of pages, you talk about the differences of projections made last summer and the current projections which you see which are much lower. Could you explain, in case it was asked before, why that came about? And how do you verify the figures that you are currently speaking about? Or will the fall come by and we will see new figures?

Ms. O'NEILL. Well, making projection is partly an art form. It is not an exact science.

Mrs. MINK. Well, what art form was being used last summer?

Ms. O'NEILL. There is always some uncertainty. For example, we don't know for sure what will happen to the AFDC caseload, which has a big impact on the number of Medicaid beneficiaries. So if we had been expecting that the AFDC caseload would be somewhat larger but it turned out to be somewhat smaller, that would be a reason.

The difference in 1994 was that the actual expenditure was somewhat less than what we had been projecting. We had been projecting $84 billion. It actually came in at $82 billion. It wasn't a huge difference in the orders of magnitude that you would expect for a random error. But expenditures came in lower than we had been anticipating, and for that reason, we lowered our projections to conform with what 1994 actually produced, and being closer to 1995, we also lowered projections for that year. Since that was the jumping-off point for our projections, they were therefore lower.

It did seem as if there was more than the usual amount of uncertainty over the next 5 years because we were trying to predict what State behavior would be. On the one hand, you see States applying for waivers that would expand their Medicaid populations, waivers that would allow them to bring into the Medicaid program children who come from families with higher income levels than are now covered. That could cause expenditures to rise quite rapidly.

On the other hand, some States are now moving into managed care. If managed care programs are actually successful in reducing Medicaid costs, we would have that to contend with.

So it is hard to know between these two positions because we are really trying to project what States are actually going to do, which way will they go. Will they lean toward expansion? Will they lean toward constraints?

I think that is the difference between CBO's and OMB's projections. OMB was leaning toward the more constrained, and we said States are going to be more constrained than they have been. Because of the increase in waiver activity and the continuing expansion that has already been legislated, however, requiring the inclusion of children and families who are poor and don't receive cash welfare benefits, there will still be pressures for increases. Not as great as before, but still increased.

Mrs. MINK. Thank you very much.

Mr. MILLER. We need to move on. Thank you very much.

Ms. Woolsey.

Ms. WOOLSEY. Thank you, Mr. Chairman.

Dr. O'Neill, I think everyone on this committee agrees that increases in medical spending is one of the biggest obstacles we have

in this country to balancing the budget. And we also agree that we have to look at ways to be cost-effective when we are taking care of the health of our most vulnerable citizens, and those are those who are covered under Medicaid. And I really appreciate your being here to help us look at what we can do about this.

But I would like to point out a cause-and-effect concern that I have that I think we are being very shortsighted about and see what you think when we are looking at Medicaid savings. I don't think our focus should be entirely on the Medicaid system. I think we need to also focus on programs outside the Medicaid system, which really end up saving Medicaid in the long run, saving dollars. And what I am particularly talking about is child nutrition programs.

There are a lot of people who criticize the President on his budget saying that he has made no attempt to control Medicaid spending, and I believe they are not accurate because his budget ensures that child nutrition programs, which ultimately save Medicaid dollars, get the funding they need.

For instance, his proposed budget increases about $300 million for supplemental food programs for Women, Infants, and Children, and studies have shown that every WIC dollar saves $4 which would later be spent on Medicaid.

So my question, after I politick a little bit: Don't you think one of the ways we can promote Medicaid savings is by ensuring that child nutrition programs like WIC are sufficiently funded?

Ms. O'NEILL. Well, my opinion is not relevant, but I would point out——

Ms. WOOLSEY. It is relevant.

Ms. O'NEILL. CBO confines itself, you know, to providing information analysis and cost information. But I would point out one thing in trying to think about that issue. That is to ask what the level is, not what the increase is. What is the level of nutritional spending on the poor? And is it at present inadequate or adequate? You have to think about the link between spending on these programs and actual nutrition. I don't think measured nutritional adequacies is really clear.

Ms. WOOLSEY. But cutting WIC and other nutrition programs, don't you think they could actually lead to an increase in the deficit by boosting Medicaid costs?

Ms. O'NEILL. I don't know what the link between that and medical expenditures is.

Ms. WOOLSEY. Well, I think that is one of the problems with how we cost things in this Congress, is we don't look at any of the up-front investments that make long-term savings, and I am having a hard time with that because it makes sense to invest up front so we can save later. I am looking for somebody official, like yourself, to say, yes, you are right.

Thank you. [Laughter.]

It doesn't sound like you want to say that.

Thank you, Mr. Chairman.

Mr. MILLER. Mr. Olver.

Mr. OLVER. Thank you, Mr. Chairman.

I will have to admit that I have not been able in one sitting to read the document which is your testimony, Ms. O'Neill, and so I

am sort of having to pick up a little bit from things that other folks have been saying.

First of all, let me ask you, the projections which you give in Table 4 on page 31 of your testimony for the Congressional Budget Office for the years from 1994—which are clearly history and, indeed, finally, Congressional Budget Office and the OMB does agree on that—and the year 2000, when were those projections made by CBO?

Ms. O'NEILL. These are our most recent projections. They were made in February.

Mr. OLVER. So in February of this year. That would be before you were actually—before you took on the job as Director?

Ms. O'NEILL. That is probably true.

Mr. OLVER. I note, for instance, that the projections, at least on the part of OMB, whatever the art or artifice is in projections, the projections of OMB from 1995 through 2000 are about a 54-percent increase over that period of time. What I don't see anywhere is any set of projections that would correspond to that, which also, I suppose, would have some combination of art or artifice, for what the increase in population would be. But there is a 54-percent increase there.

I suppose this in part goes back to what the gentleman from California, who is now gone, had been talking about earlier. On page 4, you have your table of Medicaid beneficiaries, and in that, in a similar 5-year period—not by any means the same, and I will not make the mistake of trying to make more of this than should be. From 1988 to 1993, the number of recipients, the beneficiaries, the Medicaid beneficiaries, went up from 22.9 to 33.4, which, with rounding, is essentially a 50-percent increase in the number of beneficiaries.

Now, in no period recently under censuses has the population of the United States gone up more than about a percent per year. So a 5-year population increase would be about a 5-percent increase in beneficiaries. So something is going on there. What would you tell me, what would you say is going on there?

Ms. O'NEILL. You have noticed something that is unusual about that period. Before 1988—say between 1975 and 1988—the number of beneficiaries in Medicaid really didn't grow very much at all.

Mr. OLVER. From when?

Ms. O'NEILL. Between 1975 and 1988, Medicaid beneficiaries increased very little.

Mr. OLVER. Do you know what they were in 1975?

Ms. O'NEILL. I don't know the exact amount, but they had been——

Mr. OLVER. So it is relatively stable?

Ms. O'NEILL. It had been relatively stable.

Mr. OLVER. Now, wouldn't that suggest——

Ms. O'NEILL. What happened then was that a series of legislative mandates expanded the program. In part, that was because there was the expansion of the program to children and families who were poor but were not cash recipients and who were not in single-parent families. That was part of the story.

In addition, it was an expansion to children who were in near-poor families, up to 133 percent of the poverty line.

Mr. OLVER. Your pie charts following—and, interestingly, pie charts are wonderful things to work from, but it also would be very instructive—the gentleman from Texas, it would be nice to know how big the whole pie is at the same time that you are seeing what has happened to the proportions, because in the one on the next page, the proportion of children has gone up very substantially, while you can see that that is also true in Table 1 where the number of children who are eligible children.

Now, either that means there are more children growing up in poverty, which is basically what Medicaid eligibility represents, or else there has been a whole lot of additional changes in law, which I think you have suggested. And I am not sure——

Ms. O'NEILL. It was both.

Mr. OLVER [continuing]. But one has to take what both of those things. OK. You just said that it was both.

Ms. O'NEILL. It is both, yes. The expansion was one element, but in addition to that, during the recession there was a very substantial increase in the AFDC caseload. And that brought on——

Mr. OLVER. OK. So could we just say——

Ms. O'NEILL [continuing]. Automatically a large number.

Mr. OLVER [continuing]. That the reason that costs have gone up so much for Medicaid is that there are a lot more people on Medicaid, which goes beyond what is the normal, let's say, inflation of medical costs in the general population.

Ms. O'NEILL. Right.

Mr. OLVER. And if you had a group of people who were the employees of a State which were constant or going down, as in many States they were during that period—and certainly now the number of Federal employees is going down—you really cannot compare at a time when the Medicaid population is going up, either through expansion of eligibility by law or expansion of poverty.

Ms. O'NEILL. That is right. Both of those factors came into play in the period between 1988 and 1993.

Mr. OLVER. Now, I would just like to point out that on your chart on Figure 3 on page 8——

Mr. MILLER. We are getting behind schedule quite a bit.

Mr. OLVER [continuing]. Where I listened to the gentleman from Texas trying to discern what it was that was going on there, this is a particular case where it would be extremely helpful if the size of the pie was shown, because the size of the pie clearly in the bottom chart should be half again as large, 50 percent larger. And still, I suspect, you would have a lot to explain as to why the total amount of hospital costs has gone up so very much.

The hospital cost has gone up astronomically in that period, and it is not for children. Children are not the components of hospital costs. It is mostly elders who are the component of hospital costs.

Ms. O'NEILL. DSH payments account for a lot of that.

Mr. MILLER. We are behind schedule, so——

Mr. OLVER. Well, that is right, but that is mostly for elders.

Mr. MILLER. We need to conclude.

Mr. OLVER. It is not children who are going into the hospital.

Ms. O'NEILL. We can provide you with that information, if you would like.

[The information requested follows:]

In response to your request we are providing the following information for the record. Excluding expenditures for administration, total Medicaid spending was $51 billion in fiscal year 1988 and $127 billion in fiscal year 1993.

Mr. MILLER. Thank you. I am sorry, we are already behind our overall schedule for today, but Mr. Sabo has a couple more questions.

Mr. SABO. Thank you, Mr. Chairman.

Dr. O'Neill, if you would look at that same chart on page 4, I am just curious about the number of people that are working and that we are providing Medicaid coverage for because their employers are not providing health insurance. The elderly, I understand the distinction between cash recipients and other beneficiaries, but when we look at disabled, the other beneficiaries is 1.3. They are receiving Medicaid but not cash assistance. Adults, other beneficiaries are 2.9. Children, other beneficiaries 6.6 percent. So those are from families who aren't receiving cash assistance.

If I add those three items up, we have 10.8 million people. Would it be fair to assume that the bulk of those are people who were either the adult or the parent of kids who are working and are primarily people in the labor force getting health care benefits under Medicaid because they aren't receiving it through their employer?

Ms. O'NEILL. Certainly, a larger percentage of the adults, the nondisabled adults, would include people who were lower earners, and certainly the children would be part of families in which the parents were low earners. And it is true that there has been a decline in coverage for people with low earnings over the past decade or so.

Some of it goes the other way, too. It is possible that if an employer, seeing that Medicaid was expanding and taking care of more of the families of the near poor—of near-poor families with children—also reduced coverage. I think it can go both ways, and I think it may very well have done so.

Mr. SABO. Medicaid is really the ultimate, by far the largest distribution formula of Federal funds to State and local government of any program that exists. It dwarfs the highway program or AFDC or anything else. So I expect all of us want to understand our own State and how changes may impact it.

I frankly have trouble understanding the numbers from my own State. Minnesota is roughly 1.8 percent of the Nation's population. Our average income is around average. And so when I look at Federal distribution formulas, if we are a little under 2 percent, the 1.8 category, I figure there isn't much I can complain about. But I look at Medicaid and we are 1.6 percent of Federal Medicaid expenditures in 1993. We had actually dropped. Another one here showed 1988, and I think we were up to 2.3 percent. But by 1993, we were clearly lower than our average percentage of population.

On the other hand, I looked at another chart here from GAO, and we were one of the highest States in expenditures per capita. We were one of five or six States that spent over $5,000 per capita.

Now, I don't know if offhand you could explain it to me, but it just strikes me as an odd combination because our total Federal share is less than what I might expect, but clearly we are spending significantly more per recipient than most States in the country.

Ms. O'NEILL. A number of factors could account for that. Minnesota may have high standards, have high-quality care in general, and that may be true for the Medicaid population as well. Or it could be compositional. One would really have to go into it.

I would also say that in looking at any of these State numbers, they are often less reliable than the totals because sometimes the reporting is partial. You will see something for one year, and then you will look for another year. The numbers seem to jump around, and they could be doing so because not all the counties have reported. The reporting systems are not as wonderful as one might like.

Mr. SABO. Isn't generally our data on health care pretty atrocious?

Ms. O'NEILL. They are. It is surprising, considering how significant health care has become, that we have such limited information. I think it is very unfortunate.

Mr. SABO. Thank you, Dr. O'Neill. Very good testimony.

Mr. MILLER. Mr. Hoke.

Mr. HOKE. Thanks, Mr. Chairman.

It is interesting that I walked in just as my friend and namesake from Minnesota was finishing his questions, because I wanted to ask him, I have been looking at this same table and trying to figure it out. When you go down it—and I put little minuses and pluses next to different States' names in terms of who was getting more and who was getting less.

If you look at, for example, California, according to Table A–1, California has 13.9 percent of the U.S. poverty, but only 9.8 percent of the Medicaid expenditures; Florida, 5.7 percent of the poverty population of the United States but only 3.7 percent. They are losers, right? But then you go to Illinois. Illinois has 4.9 percent of the poverty population, 3.4 percent of the expenditures. Illinois is a loser also.

Let's find a winner here.

Ms. O'NEILL. New York. There is one.

Mr. HOKE. New York, thank you. Big winner, 12.5 percent of the expenditures, only 7.5 percent of the population. New Jersey, another big winner, 3.4 percent of the expenditures, 2.3 percent of the poverty population. Pennsylvania, big winner. Another one is, interestingly, Louisiana, a winner. And so is Indiana.

Now, what is the explanation for that? A, what is the explanation for it? And doesn't it strike you that this highlights some fundamental inequities, unfairnesses, with respect to the way that we are distributing these dollars? And how does that—can you sort of decipher this in a way that would either encourage me to think in terms of block granting welfare money or to using some sort of a formula that would be more fair? Because how is it possible that the system can be so gamed that there could be these really tremendous discrepancies in the way that dollars go on a per capita basis to the different States?

Ms. O'NEILL. Under the current system, it is really the States that determine—that have a lot to say about—who is eligible for their programs, the reimbursement rates that are paid to providers, the package of services that will be offered, how generous or how strict control will be, and all of the kinds of factors that will

cause cost variation. And the Federal Government pays the share based on the per capita income of the State, regardless of what the total is.

There are certain things that are disallowed, but the States really have a very wide margin. It is really State discretion that will——

Mr. HOKE. But does that mean that if every other State in the Union decided in this year—that the legislatures in all the other States other than New York were going to now begin to offer the exact same benefits package that New York offers, that we could see an incredible spike?

Ms. O'NEILL. The Federal bill would jump, would escalate. So would the other States'——

Mr. HOKE. We have no control over that?

Ms. O'NEILL. That is right, because there would be nothing illegal about it.

Mr. HOKE. But it seems to me that that certainly argues in favor of a block grant by a formula type of approach because it would require—I mean, it would at least give us some certainty about how much money we would be budgeting, and then require the States to work out their own plans within the amount of money that they are given?

Ms. O'NEILL. Yes, I think that is one conclusion that one might draw, because there is, as you point out, a lot of State variation. It is something different in the case of each State. New York has a very generous benefit package. Another State like Louisiana has relatively high DSH payments. So each State has a somewhat different story, and you do end up with a large percentage of Medicaid expenditures going to particular States.

Mr. HOKE. But what it boils down to is that my constituents, the taxpayers of Ohio, are subsidizing the taxpayers of New York.

Ms. O'NEILL. To some extent, that has to be true.

Mr. HOKE. And there are winners and losers in this game in a way that reflects the State's appetite for indigent health care services as decided by the State legislatures and the Governors.

If you want to take advantage of this, either through DSH or through making the most comprehensive kind of basic package available, you can do it. Apparently, New York has done it pretty dramatically. They have gotten the lion's share of the Medicaid moneys that are available.

I see my time has expired. Thank you, Mr. Chairman.

Mr. MILLER. Thank you. We are running a little tight on time. Mrs. Myrick.

Mrs. MYRICK. Excuse me. If you have answered this, I am sorry. I haven't been able to be here the whole time. I come from a State—North Carolina—that is concerned about losing roughly 20 percent of their funds if there is a cap on entitlements. The block grant proposal, can you devise a formula that will fairly distribute Federal Medicaid funds to the State, do you feel, under this system? Then, also, is it practical that you would take into consideration the rates of growth in the different service categories?

Ms. O'NEILL. No, CBO would not decide. That would be the Congress. It will be a matter to be negotiated. I assume that considerations such as those will certainly be brought to the table by the

individual States who will be able to make the case that they have populations that have unusual—that generate higher than average——

Mrs. MYRICK. Do you think that is something that could be done? Just from your experience with working with numbers, working with budgets, et cetera, is that something you think could be worked out?

Ms. O'NEILL. I think that certain basic facts could certainly be determined about the States, although State-level data are usually much less available than data at the national level. Nonetheless, help could be given in terms of the facts, the proportion of disabled, the proportion of elderly, the proportion of poor children in a State. Facts like those can certainly be provided.

Mrs. MYRICK. Thank you.

Mr. MILLER. Dr. O'Neill, just to conclude with a couple comments. So many of the questions this morning have been on individual State versus State issues, and I know from Florida I have that concern about the State issue. But the bottom line is this has been on auto pilot just going out of sight as far as spending, and your projections and the OMB numbers are showing us going out of sight, too. But the basic concept is to rein it in, and if we go the block grant route, at least there is going to be a way to control it—if we can come up with a formula that is fair and equitable to all the States, and that is part of the key.

I thank you very much for being with us today and look forward to having you here at another time on another subject before this committee. Thank you, Doctor.

Ms. O'NEILL. Thank you for the opportunity.

Mr. MILLER. We will proceed immediately now with the rest of the program. Thank you.

Mr. MILLER. The next panel will be Dr. Bowsher from the General Accounting Office, and he has several people with him.

STATEMENT OF CHARLES A. BOWSHER, COMPTROLLER GENERAL OF THE UNITED STATES; ACCOMPANIED BY WILLIAM SCANLON AND JAMES COSGROVE

Mr. MILLER. Dr. Bowsher, thank you very much for being here today. Welcome and you have two gentlemen with you. If you would introduce them we would appreciate it, and then you may proceed with your testimony, sir.

Mr. BOWSHER. It is a pleasure to be here. With me today is Bill Scanlon on my right, and on my left is James Cosgrove.

We have a statement which I would be pleased if you could put in the record. I will summarize it. We are also releasing two reports today, Medicaid Spending Pressures Drive States Toward Program Reinvention; and another one, Medicaid Restructuring Approaches Leave Many Questions.

We are here to discuss the issues which you asked us to examine which is one, Federal and State Medicaid spending trends; two, States efforts to contain Medicaid costs and to expand coverage through waivers of certain Federal requirements; and three, the potential impact of the waivers on Federal spending.

In brief, Dr. O'Neill went over many of the numbers. I think you can see here that more controls over costs in the Medicaid program

are very important because the 1993 expenditures reached $131 billion. That is $100 billion more than a decade ago. Medicaid today consumes 6 percent of all Federal outlays. And it is three times that of food stamps and five times that of AFDC.

Medicaid growth outpaces that of most major items in the Federal budget today, including Medicare. Without modifications, CBO predicts that Medicaid could double in cost in the next 5 to 7 years.

Now, equally important is that Medicaid is also the fastest growing component in most of the State budgets. And consequently States are now, one-by-one, trying to reinvent their Medicaid programs under the authority of section 1115 waivers.

Since 1993, HCFA has approved implementation for seven statewide demonstration waivers. Four States, Oregon, Hawaii, Tennessee, and Rhode Island have implemented or started to implement their new programs.

Three other States have been approved but have not started to implement. These are Florida, Kentucky, and Ohio. Florida and Ohio have not gone forward because their State legislatures have not passed necessary legislation, and in Kentucky the State legislature doubted that savings from the managed care approach would be sufficient to offset the costs associated with coverage of additional groups.

Now, these waivers address States' needs in two ways. They allow States greater flexibility to test such cost containment strategies as capitated managed care, and two, they allow States to expand program eligibility beyond traditional Medicaid populations.

What that means, Mr. Chairman, is that savings are being used to expand the Medicaid population and are not coming back to the Federal Government.

Now I would also like to point out here that requiring States to obtain waiver approval in order to pursue their managed care strategy is burdensome and may hamper their cost containment efforts. Moreover, allowing the waiver process to be used to expand coverage to hundreds of thousands of additional individuals without consultation and concurrence of the Congress does appear to be inappropriate. The result of these waivers could lead to a heavier financial burden on the Federal Government.

Our analysis suggests that some approved statewide section 1115 demonstrations may not be budget-neutral. It indicates that the granting of additional section 1115 waivers merits further scrutiny for the following reasons.

First, the administration is allowing States to apply the Federal share of Medicaid savings from managed care to finance coverage of additional populations not included under Medicaid law. At issue is whether the Federal Treasury should benefit from these savings, and whether eligibility should be made available for new groups only after congressional debate and legislative action.

Second, the administration's method for determining budget neutrality may allow States access to more Federal funding than they would likely receive without the waiver.

How the administration assesses the budget neutrality of additional waiver proposals may greatly affect Medicaid spending in the years to come.

And third, the Congress may find it difficult to scale back section 1115 demonstrations if they prove more costly than forecast.

A demonstration waiver granted for a limited period of time may be a shortsighted approach to reducing States' uninsured populations. If at the end of 5 years, the demonstrations have cost much more than they estimate, the Congress may face the choice of either increasing Federal funding, or relying on the States to reduce benefits or deny coverage to hundreds of thousands of people newly enrolled under the waivers.

In conclusion, I am reminded that millions of Americans, not only poor mothers and children, but also poor elderly, blind, and disabled individuals depend upon health care made possible by the Medicaid program. However, the program's double-digit spending growth rate imperils efforts to bring the Federal deficit under control.

Because current program restrictions on managed care serve to reinforce quality assurance, in the absence of these restrictions, continuous oversight of managed care is required to protect Medicaid beneficiaries from inappropriate denial of care and Federal dollars from payment abuses.

Finally, we believe that the potential for increased Federal spending, under future statewide demonstration, warrants close scrutiny of the section 1115 waiver approvals.

Mr. Chairman, that concludes our prepared statement and we would be pleased to answer any questions that you might have.

[The prepared statement of Charles A. Bowsher follows:]

PREPARED STATEMENT OF CHARLES A. BOWSHER, COMPTROLLER GENERAL OF THE UNITED STATES

Mr. Chairman and members of the committee, we are pleased to be here today to provide the committee current information on the status of the Medicaid program. For years, GAO has looked for opportunities to improve the program's efficiency and to constrain spending growth.[1] We are here to discuss our report on Medicaid spending pressures, which is being released today.[2] You asked us to examine: first, Federal and State Medicaid spending trends; second, States' efforts to contain Medicaid costs and expand coverage through waivers of certain Federal requirements; and third, the potential impact of the waivers on Federal spending.

You and others are currently engaged in a debate over options for cost containment in the Medicaid program, which in 1993 spent $131 billion. Medicaid growth outpaces that of most major items in the Federal budget, including Medicare, and without modification, spending is likely to double in the next 5 to 7 years. Medicaid is also the fastest growing component in most State budgets at a time when States are feeling pressured by many financial constraints and when many are looking for ways to provide care to their uninsured populations.

In response, States are one by one reinventing their Medicaid programs by seeking section 1115 waivers from the Health Care Financing Administration [HCFA], which oversees the Medicaid program. Named for Section 1115(a) of the Social Security Act, these waivers free States from certain Medicaid restrictions on the use of managed care delivery systems. They also allow States to expand Medicaid-financed coverage to individuals not normally eligible for Medicaid.

To summarize, requiring States to obtain waiver approval in order to pursue their managed care strategies is burdensome and may hamper their cost containment efforts. Moreover, allowing the waiver process to be used to expand coverage to hundreds of thousands of additional individuals without the consultation and concurrence of the Congress appears inappropriate. The result of these waivers could lead to a heavier financial burden on the Federal Government.

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[1] See Appendix for list of related GAO products.

[2] "Medicaid: Spending Pressures Drive States Toward Program Reinvention," GAO/HEHS–95–122, April 4, 1995. We are also releasing today a related study entitled, "Medicaid: Restructuring Approaches Leave Many Questions," GA0/HEHS–95–103, April 4, 1995.

In this statement I will present a more detailed look at Medicaid's growing expenditures, describe States' efforts to obtain section 1115 waivers, and summarize the expenditure forecast of programs operating with waivers.

MEDICAID CONSUMES GROWING SHARE OF FEDERAL BUDGET

In 1993, Medicaid spent almost $100 billion more than it did a decade previously. Currently, Medicaid consumes about 6 percent of all Federal outlays—3 times the share devoted to food stamps and 5 times the share devoted to Aid to Families with Dependent Children. The Congressional Budget Office projects Medicaid's annual growth rate at almost 11 percent for the next several years. Medicaid has also grown rapidly in size. In 1993, Medicaid served over 33 million beneficiaries, 11 million more than in 1983.

Creative financing approaches used by States to leverage additional Federal dollars contributed to the cost growth in recent years. Part of the approach involved making payments to hospitals that served a disproportionate share of Medicaid and other low-income patients.[3] These payments exploded from a few hundred million dollars in 1989 to over $17 billion in 1992. Although legislation has limited the growth of these payments to disproportionate share hospitals since 1993, the gaming of these payments in some States has both increased the level and affected the distribution of current and future Medicaid spending.

Other factors also worked to increase Medicaid costs: medical inflation, higher utilization of services, and more beneficiaries. Although many of the new beneficiaries were pregnant women and children made eligible by congressional mandates enacted since 1984, the addition of this group played a less significant role in increasing Medicaid costs because these individuals are relatively inexpensive to serve. The pressure on Medicaid costs is expected to continue. For example, the number of individuals with disabilities receiving Medicaid benefits is growing rapidly. While this is a relatively small group, it accounts for a large share of program cost—about two-thirds of Medicaid dollars for one-fourth of the population.

STATES SEEK SECTION 1115 WAIVERS TO CONTAIN COSTS AND EXPAND COVERAGE

To deal with pressures to contain costs while confronting the problem of the uninsured, a number of States are turning to section 1115 waivers. These waivers address States' needs in two ways: they allow States greater flexibility to test such cost containment strategies as capitated managed care, and they allow States to expand program eligibility beyond traditional Medicaid populations. Since 1993, HCFA has approved for implementation seven statewide demonstration waivers: Oregon, Hawaii, Kentucky, Tennessee, Rhode Island, Florida, and Ohio. Kentucky, Florida, and Ohio have not yet implemented their programs. Another 15 States either have applications pending or have held discussions with HCFA about statewide demonstrations.

These section 1115 waivers allow States to contract with managed care organizations that enroll few or no private patients. In other words, the 75–25 rule has been waived. This rule stipulates that, to serve Medicaid beneficiaries, 25 percent of a health plan's total enrollment must consist of private-paying patients. The principle behind this restriction is that a health plan's ability to attract private enrollees can serve as one assurance of quality.

The waivers also permit States to require beneficiaries to remain enrolled in their health plans for longer periods of time than Medicaid typically requires. Allowing beneficiaries to choose to disenroll at will, as normally permitted by Medicaid, makes managed care organizations' planning for financial stability difficult and therefore the enrollment of Medicaid beneficiaries less attractive.

Medicaid's restrictions on States' use of managed care reflect historical concerns over quality. In the 1970's, reports on quality of care problems in Medicaid managed care prompted the Congress to enact certain provisions to improve quality assurance. States feel that the 75–25 rule and Medicaid's prohibition against locking enrollees into a plan for an extended period hamper their efforts to contract with managed care networks. While HCFA has agreed to waive some of the traditional requirements aimed at ensuring managed care quality, the terms and conditions of section 1115 waivers require States to operate quality assurance systems and to collect medical encounter data.

In addition to implementing widescale managed care, several States are also greatly increasing the scope of their programs by providing benefits to individuals who would not normally qualify for them. For some demonstrations, States initially

[3] "Medicaid: States Use Illusory Approaches to Shift Program Costs to the Federal Government," GAO/HEHS–94–133, August 1, 1994.

estimated high enrollments of newly eligible individuals: 1.1 million in Florida, 395,000 in Ohio, and 500,000 in Tennessee. If coverage expansions similar to these waivers are approved for more and bigger States, the Federal Government as well as the States could be providing health insurance for millions more beneficiaries.[4]

SOME STATES' SECTION 1115 DEMONSTRATIONS COULD INCREASE FEDERAL SPENDING

Section 1115 waivers, while freeing States to implement managed care cost containment strategies, could in the long run undermine efforts to contain Federal expenditures. Our analysis disputes the administration's assertion that all the approved statewide section 1115 demonstrations are budget neutral. It suggests that the granting of additional section 1115 waivers merits further scrutiny for the following reasons:

The administration is allowing States to apply the Federal share of Medicaid savings from managed care to finance coverage of additional populations not included under Medicaid law. The administration and States assume that the enrollment of Medicaid populations in capitated managed care will save States enough money to cover additional low-income people at no extra cost to the Federal Government. Even if the proposed demonstrations will not require new Federal dollars, the administration's approval of coverage expansions means that anticipated Medicaid cost savings—from more aggressive use of capitated care—will not be used to reduce Federal spending. At issue is whether or not the Federal treasury should benefit from these savings and eligibility be made available for new groups only after congressional debate and legislative action.

The administration's method for determining budget neutrality may allow States access to more Federal funding than they would have received without the waiver. Our initial examination of four States' proposed demonstrations suggests that claims of budget neutrality for these States may not be sustainable in all cases. While Tennessee's demonstration project may be budget neutral, the demonstrations in Florida, Hawaii, and Oregon may require increased financial commitment from the Federal Government. Relative to overall Federal Medicaid spending, the amount of new Federal dollars spent in States with approved section 1115 waivers is small. However, the methods used by the administration to assess the budget neutrality of pending and future waiver proposals may greatly affect Federal Medicaid spending in the years to come.

The Congress may find it difficult to scale back section 1115 demonstrations if they prove more costly than forecast. A demonstration waiver, granted for a limited period of time, may be a shortsighted approach to reducing States' uninsured populations. If at the end of 5 years the demonstrations have cost much more than estimated, the Congress may face the choice of increasing Federal funding or relying on the States to reduce benefits or deny coverage to hundreds of thousands of people newly enrolled under the waivers.

CONCLUDING OBSERVATIONS

Over 33 million low-income women, children, elderly, blind, and disabled Americans depend upon health care made possible by the Medicaid program. However, the program's double-digit spending growth rate imperils efforts to bring the Federal deficit under control. Consistent with the committee's interest in constraining Federal spending, States believe they need the flexibility to manage their respective programs. Requiring States to obtain waiver approval in order to aggressively pursue managed care strategies may hamper their cost containment efforts. Yet, because current program restrictions on managed care were designed to reinforce quality assurance, in the absence of these restrictions, continuous oversight of managed care systems is required to protect both Medicaid beneficiaries from inappropriate denial of care and Federal dollars from payment abuses. Finally, we believe that the potential for increased Federal spending under future statewide demonstrations warrants close scrutiny of the section 1115 waiver approvals.

Mr. Chairman, this concludes my prepared statement. I will be happy to answer any questions you or the other committee members may have.

APPENDIX.—RELATED GAO PRODUCTS

"Medicaid Long-Term Care: Successful State Efforts to Expand Home Services While Limiting Costs," GAO/HEHS–94–167, August 11, 1994.

[4] "Increasing Insurance Coverage Through Medicaid Waiver Programs," the Urban Institute, Washington, DC: November 1994.

"Health Care Reform: Potential Difficulties in Determining Eligibility for Low-Income People," GAO/HEHS–94–176, July 11, 1994.
"Managed Health Care: Effect on Employers' Costs Difficult to Measure," GAO/HRD–94–3, October 19, 1993.
"Medicaid Drug Fraud: Federal Leadership Needed to Reduce Program Vulnerabilities," GAO/HRD–93–118, August 2, 1993.
"Medicaid: Data Improvements Needed to Help Manage Health Care Program," GAO/IMTEC–93–18, May 13, 1993.
"Medicaid Formula Alternatives," GAO/HRD–93–18R, March 31, 1993.
"Medicaid: States Turn to Managed Care to Improve Access and Control Costs," GAO/HRD–93–46, March 17, 1993.
"Medicaid: Oregon's Managed Care Program and Implications for Expansions," GAO/HRD–92–89, June 19, 1992.

Mr. MILLER. Over the last 5 years, basically Medicaid has, as Dr. O'Neill talked to us, has grown very rapidly. Have we lost control of the Medicaid program, would you say, in the last 5 years?

Mr. BOWSHER. Well, it has really gone up very dramatically as I said in my statement, faster than practically any other program in the Federal budget, and faster than even Medicare. These DSH payments are certainly a big factor in that. Also who is eligible, as she pointed out, in her testimony.

So I think there is a good reason here why the Congress should be debating these issues and trying to get more control over the program, no question.

Mr. MILLER. What would be required to get financial control over Medicaid again and what role could block grants have in that process?

Mr. BOWSHER. Block grants give you more certainty over the Federal cost control because they put a certain amount out there that the States must live within. At the same time, what is uncertain, I think, to say the least, is just what savings will come from managed care.

There are indications in the private sector that managed care is achieving savings. There are indications, like in the demonstration waiver in Tennessee, that they have been able to achieve some savings in that.

We are not quite sure, yet, how much and how long-term those savings will be.

Mr. MILLER. You mentioned Tennessee and I have heard people talk about it, even in Florida. Would you comment briefly on the satisfaction level and the success and failure of the Tennessee situation so far?

Mr. BOWSHER. Tennessee is a mixed result, I think. In other words, they are gaining more coverage. They have over 400,000 additional people now under the program. Their cap is 500,000 additional people than before they went into this program.

A majority of the previous Medicaid people, a good portion of them are as satisfied with TennCare as they were with Medicaid, but then there is 45 percent, in a recent survey, that said they were less satisfied. So it is still a mixed situation, I think, down there in Tennessee.

Mr. MILLER. OK.

Mrs. Mink.

Mrs. MINK. Thank you, very much, Mr. Chairman. I regret that I have not had the opportunity to read your two reports, but I certainly shall. The points of interest to me, particularly, is that my

own State has obtained a waiver under the Medicaid provisions that you testified to. Could you just briefly comment on your findings with respect to Hawaii and whether they have been able to achieve the savings and participation rates that were indicated at the outset of this program?

Mr. BOWSHER. Let me ask my colleague, here, to talk about Hawaii.

Mr. COSGROVE. My understanding of the situation in Hawaii is that more people have actually signed up for the new program than the State originally anticipated. I do not have measures of satisfaction or dissatisfaction from the Hawaii situation.

Mrs. MINK. In your testimony you indicated that one of the unanticipated problems that might arise with the reliance on State waivers is that you would find a larger number of participants that did not necessarily meet the Federal criteria. Did I understand your comments?

Mr. BOWSHER. That is correct.

Mrs. MINK. And so that means then that there would be a larger anticipated expenditure than is now projected for the Medicaid program, is that your conclusion also?

Mr. BOWSHER. Well, that is the potential here. In other words, as additional people are brought into the program the hope is, these demonstration waivers will be budget neutral. And that is the way the administration has approved them. But in looking at the programs that we have examined here, we see a large number of additional people being brought into the programs and we are not sure that that will not eventually lead to larger costs, both for the State and the Federal Government.

I think that is one of the reasons why some State legislatures have been reluctant to go forward with their waivers. They are concerned about what the total cost will be to their States, in addition to the Federal Government.

Mrs. MINK. As I understood the Hawaii situation there was an absolute commitment that the cost sharing by the Federal Government would not go up except for the regular anticipated average increases that other programs, other States experience. Is that not the situation? So that the larger numbers of people that are included in the program does not necessarily mean that there would be a higher percentage of cost to the Federal Government.

In fact, the whole purpose of it, as I understand, was to put a lid on the expenditures because the State was concerned that its contribution was rapidly rising beyond what they could afford.

Mr. BOWSHER. That basically was what they were hoping to achieve. In other words, they were hoping to achieve savings because of the greater flexibility in running the program, and therefore, they were hoping that the additional people would not cost more.

But what we are saying is that when we look at some of these large numbers being projected, like a million people in Florida and 500,000 in Tennessee, this raises a very big yellow flag about what it might eventually cost.

Mrs. MINK. This is over and above the commitments that were made at the time that the waiver approvals were given by the Federal Government. You are saying that beyond that 5-year period or

whenever these waivers expire, that the system might find a larger number of people on board than were on board, in fact, when the waiver was first granted. Is that correct?

Mr. BOWSHER. That is correct.

Mrs. MINK. Thank you, very much.

Mr. MILLER. Mr. Smith.

Mr. SMITH OF MICHIGAN. Thank you, Mr. Chairman.

I have questions on the increased costs that have come from an expanded population, claiming benefits, as opposed to the resulting increased cost of medical care due to technological advances. Have you ever looked at that?

Mr. BOWSHER. We have done work on the overall health care issue, and certainly technology is one of the big cost drivers in all of the health care programs, no question.

Mr. SMITH OF MICHIGAN. I am sorry, I missed your opening statement. Did you project any estimate of the cost from cheating, from both parts?

Mr. BOWSHER. You mean fraud?

Mr. SMITH OF MICHIGAN. Yes.

Mr. BOWSHER. Yes. We have done work on that in the past, and we generally say it is both fraud and abuse. Because lots of times it is hard to prove the intent that gets it into fraud. But I think a lot of people in all of the government health care programs think there might be as much as 10 percent loss because of both fraud and abuse.

Mr. SMITH OF MICHIGAN. And how would that break down between the provider and the recipient?

Mr. BOWSHER. I am not sure.

Mr. SMITH OF MICHIGAN. As you investigate the application of the program in different parts of the United States, do you see a regional difference or a city/rural difference?

Mr. BOWSHER. We have not done that kind of a comparison. We have investigated the pill mills and some of the really bad fraud situations in certain particular localities, because we thought that there was a problem there. But we have not compared rural to city or the Far West or the South or anything like that.

Mr. SMITH OF MICHIGAN. Mr. Bowsher, do you publish your investigations and the report of those investigations? What has been your most recent pursuit that you have analyzed and printed now?

Mr. SCANLON. With respect to Medicaid, it would be the work on the pill mills. With respect to Medicare, we have been looking at the issue of rehabilitation therapy and durable medical equipment billing abuses.

Mr. SMITH OF MICHIGAN. I am sorry, rehabilitation therapy and?

Mr. SCANLON. Rehabilitation therapy and durable medical equipment abuses. We have been looking at those from the perspective of the Medicare program and how the price per unit of service is being inflated and how there may be an excessive number of service units being provided.

Mr. SMITH OF MICHIGAN. And as far as the varying application of the program, what is happening in terms of prioritizing health care? Have you evaluated that? Is that now being applied in some States with a waiver?

Mr. SCANLON. In the State of Oregon, one of the unique features about their waiver is that they went through a process of trying to prioritize medical services. They have developed a list of what they regard as the most important services to deliver. They have indicated that services at the bottom of the list are not going to be provided on a routine basis because they cannot afford them. They would rather use the money that they are saving to expand coverage to other populations.

They will provide some of those services below the line they have drawn when, for instance, people that are disabled need those services, in combination with other services, to try to deal with their disability.

Mr. SMITH OF MICHIGAN. But the Oregon plan for prioritization is operating now, is that correct?

Mr. SCANLON. It is operating now and it is the only one in the country that is like that.

Mr. SMITH OF MICHIGAN. OK. Mr. Chairman, thank you. I have no other questions.

Mr. MILLER. Thank you. Mr. Olver.

Mr. OLVER. Thank you, Mr. Chairman.

I have been still puzzling over the CBO data and you have added a whole new set of data which adds additional things to puzzle about, because I have an Appendix 1 in your document which gives the expenditures for fiscal year 1993, and the statistics on Medicaid expenditures for fiscal year 1993 in Table A–1 of the CBO document.

And they are really quite different. New York State, for instance, is $2 billion difference between the two tables; Pennsylvania is a similar percentage difference. The sum total makes it a little bit difficult to know exactly where to place one's thrust or trust in the figures that are out here to discuss them.

But basically the Medicaid program is one where the States, under the present law, have—there is a minimum level of services that must be provided for people who are eligible by Federal definition, and then a whole series of services that you can go beyond, State-by-State.

So that some States have offered more expansive services, and the States also decide what is the reimbursement level, what charges are going to be allowed for those.

So that adds into it. So you end up with—the discussion that we had about losers and winners earlier, some of the States, it is interesting. The percentage reimbursement by the Federal Government is set by roughly the per capita income. So you find there is a series of States at 50 percent, the States which have the highest per capita income, they are set at 50 percent. And then the others trail up to higher numbers along the way.

Mr. BOWSHER. Yes, they cannot go over 83 percent, but they can go up to 83 percent.

Mr. OLVER. Well, whatever that is, the highest number that I know of there is somewhere around 75 percent or thereabouts as the reimbursement. And 79 percent is Mississippi, that is the highest one on that reimbursement level.

Mr. BOWSHER. Yes. That is right.

Mr. OLVER. Interestingly enough, the ones who are the winners under the present law in that process, because there are a whole series of them, the States of Connecticut and Massachusetts, New York, Pennsylvania, New Jersey are winners in that present system. They have one out of six of the poverty population, but one out of four of the total expenditures. Now, in those States, if one goes to block granting, and if one fixes the number, as has often been done with block granting, at the amount that was expended in 1995 or 1994, or whatever, some base year, then those States which are present winners under the system as it has been functioning would be huge potential losers. The pressure on them would be enormous, would it not?

Mr. BOWSHER. Yes, I think it would.

Mr. OLVER. Interestingly enough those States are all big States with Republican Governors that would have a good deal of pressure on them. Of course, California would be a, who is a loser under the present system, would not notice any problem at all probably with the block granting.

But this other group that I mentioned, would have major serious problems in the process of block granting if one does not change the whole formula under which one would set that up.

If we were to freeze the shares at some point where they were and some at some earlier time, then whatever the inequities that were built in there that were inequities, some might view them as inequities, but some, because of the reimbursement rates and the poverty rates and so forth, it was a grand formula that may not have been exactly ideal, but it was there. They would be very seriously affected by the end result.

Mr. BOWSHER. And also those DSH payments have brought in a certain inequity.

Mr. OLVER. Now, interestingly enough, the data on that pie chart that we were talking about—and I am sure you have seen it, I am really going back to that because I am looking for your thoughts on that—interestingly enough, between 1988 and 1993 the hospital costs went up more than triple—I have now managed to dig out enough data from other places, within the parts, to discover this—while the costs at nursing homes have gone up a little bit less than double, maybe 80 percent or thereabouts that they have gone up during the same 5 years.

And oddly enough, again, it is the children who have gone up in eligibilities during that period of time and I think we all know, or would you not agree, that it is not children who are spending time in hospitals, but generally people toward the end of life.

Mr. BOWSHER. But you do have a certain population of children—the crack babies, and the neonatal care babies that——

Mr. OLVER. Low-birth-weight babies.

Mr. BOWSHER. Yes, low-birth-weight babies and they run up some very large bills. I do not know the data behind that pie chart, but I think there is a——

Mr. OLVER. Maybe some disabled children would be in there.

Mr. BOWSHER. Yes, and there is also an elderly population. When we have visited many of the medical centers, as I have with my team over the last few years, I have been struck by how high costs

are for that part of the program. It is at the end of life, it is at the beginning of life where a lot of our costs are——

Mr. OLVER. It is the disabilities that are getting involved.

Mr. BOWSHER. Yes.

Mr. OLVER. Disabilities that are built in by injury or drugs or something like that, built in at the beginning.

Mr. BOWSHER. Right, yes.

Mr. OLVER. The thing is going up——

Chairman KASICH. I am sorry, the gentleman's time has expired and I know you have a lot of thoughtful questions here. Let us complete this round and we will come back to you if you want to stay.

The gentle lady from North Carolina, Mrs. Myrick.

Mrs. MYRICK. Thank you, Mr. Chairman.

It is my understanding that up to $3 billion in the 1993 and 1994 disproportionate share payments and funds generated by tax and donation schemes are still in dispute. According to a January 30, 1995, Washington Post article, HHS told 18 States and the District of Columbia that they may have to refund up to $3 billion because they used illegal methods to raise their share of Medicaid matching funds. What is the current status of the HHS effort to reclaim the funds and then, are any of these funds being built into the base which is being used to fund the 1115 waivers?

Mr. BOWSHER. I think that they are still in negotiations on that. I do not think the committee, here, or the Congress or any of us should think that they are going to get a large proportion of that money back. That is my thinking because of just the magnitude of it.

I think that those negotiations are still going on. The second part of your question, are they in the base? Some of them are in the base, yes, in the waivers.

Mrs. MYRICK. Some of them are?

Mr. BOWSHER. I think they are, yes.

Mrs. MYRICK. Thank you.

Chairman KASICH. We will go to me.

How are you, Mr. Bowsher.

Mr. BOWSHER. How are you, Mr. Chairman.

Chairman KASICH. Good to see you. Let me first of all ask, on this issue of the waivers. First of all, I want to compliment you on your testimony. I read it at midnight, last night, in my spare time. I now understand what they said about Stockman. He did not sleep. I am finally beginning to realize what they meant.

You say, in your statement, that the growth of Medicaid is not consistent with our efforts up here to balance the budget. I want to compliment you on that because that is entirely correct.

The process now has been based on the fact that you get a waiver and you make a projection that you are going to save X number of dollars from that waiver and you will then use those dollars to cover more population.

If the savings do not come about, as a result of what your projections are, you could actually find yourself in a position of covering a larger population not realizing the savings that you thought would be generated and then putting yourself in the hole. Is that correct?

Mr. BOWSHER. Yes. And that is the big yellow flag that we are trying to put up here today as a result of looking at some of these waivers, and what the programs are in some of the States.

Also, some of these cost savings might turn out to be more one-time savings, we just do not know. It is well worth doing demonstration projects, it is well worth granting waivers. I do not have any problem with that.

I just think it has to be monitored very carefully. The big question is about the savings. Should there be some congressional debate as to whether a portion of the savings should be used to reduce the budget deficit or whether it should be used for increased coverage.

Chairman KASICH. Well, as you know, our philosophy now is that I have been involved since November in these discussions and you have seen the discussions and quotes from people in the Senate and from the Speaker, I think, over the weekend. I mean we have all been in these meetings. It is just that I have chosen to speak last for once in my life.

Our philosophy is that we block grant and we get rid of the rules and the regulations and let the States, themselves, serve populations. I want to tell you about a conversation I had with George Voinovich, who is the Governor of Ohio.

And his concern is that if we block grant—and he has this thing called Ohio Care where he wants to insure more people—he believes the block grant program—and he may take some issue, but I do not think so—he believes that if we block grant the money and we get rid of all the rules and regulations he will be able to accomplish his goal. His fear is that we block grant the money, keep strings on and then we not only do not give him all the money he wants, but then we keep strings on and he loses all ways.

Does it not make sense that under a block grant approach when you give a State X number of dollars, that it is then going to be up to then to decide which populations to target?

And rather than having waivers which create some theoretical basis for savings, you are dealing with X number of dollars, and your population. Would it not actually make it easier for us to have an efficient and effective Medicaid program if we gave them the money and said, hey, it is your money, there is no more to come. You figure out how to spend it. Would that not be more consistent with their being able to target the populations they want to target?

Mr. BOWSHER. It would be more consistent, and the certainty that the Federal Government is only going to spend so much on Medicaid would be greater, provided those programs are successful.

One thing I think you have to recognize, and I know you do, Mr. Chairman, is that in Medicaid you really have 56 different programs. In other words, the States have been running these programs and they run them quite differently out there. Some run them better than others. When you go to a block grant, you would give them great flexibility, I assume, and then the question is, will they run Medicaid successfully? Will they achieve the savings? Will some of these new concepts, like managed care, really pay off?

If they do not, if some of the States get into financial trouble—and Medicaid has been one of the drivers getting State budgets into deficit situations—I remember the Governor of Hawaii explaining

to me that even with a low unemployment rate, Medicaid was driving his budget into a deficit situation—then it seems to me you have the one big potential problem. Someday some State is going to come back with a really big financial problem—much like the New York City fiscal crisis—to the Federal level and they will say, gee, we did not do it right or something did not work and we are now back on your doorstep.

Chairman KASICH. Sure.

Mr. BOWSHER. I think that is your one big risk of a block grant, especially when you put a cap on, and it is still uncertain whether the States can do it within that overall dollar amount.

Chairman KASICH. But are they not in the worst possible position now because they got a bet that certain savings which gets them the waiver and allows them to insure other people—I mean it is like instead of their being able to manage their own checkbook and to figure out what they can afford, they have got somebody else in the checkbook with them. They have got somebody else out there that they got to deal with. They have got strings that come from other people.

Let me give you an example. I do not know where Governor Voinovich is on this, but it is my understanding that one of the requirements in Medicaid right now is that you must serve children up to the age of 19. And now I do not know how many people consider an 18½-year-old, who could be serving in the Persian Gulf to be a child. Do we not kind of put them in a difficult position of saying, you must meet all these rules, all these regulations, all these strings and then if you want to insure more, you get this waiver and we are not giving them the ability to have complete control over how they want to run their program.

Does that not make it more risky for them than if they could control it on their own?

Mr. BOWSHER. I do not know whether it makes it more risky. But there is no question that most of the Governors feel very similar to what you have just described. We have talked to them over the last few years as we visited them. They feel that they do not have as much control over this program because of the Feds writing a lot of the rules, and therefore this is the one item that is driving their budgets into really precarious financial shape. They all complain about it.

Chairman KASICH. Well, in the current waiver process, it makes things even more difficult for them.

Mr. BOWSHER. I would not say it makes things more difficult. I think that some of the Governors are finding that to be helpful on the waiver process. The big question is——

Chairman KASICH. But your report says that they think that X savings is going to be generated and then they increase their population. Then they find out the savings do not come, but they got the larger population. I mean that is your report. Your report is their projections are wrong.

Mr. BOWSHER. No. We are just saying that they might be wrong. And some of the State legislatures are concerned, that is why they are not actually passing legislation to go along with the waivers so far in a couple of the States, because they have the same concern. Will these enlarged populations really cost more down the road

than what the savings are? And they are just a little bit cautious on this.

Chairman KASICH. Let me ask you one other area, and that is the area of the Boren amendment. Now, I have heard these Governors ranting and raving—I mean we have a full room here today so there must be somebody in here who has an interest in the Boren amendment. That is an amendment that prohibits my Governor from being able to negotiate reimbursement rates with nursing home operators.

Tell me about this Boren amendment, Mr. Bowsher.

Mr. BOWSHER. I will let Bill Scanlon do that. He is my expert on the Boren amendment.

Mr. SCANLON. The Boren amendment certainly has had an impact over the years in restricting what States can do in paying both nursing homes and hospitals. They do have some latitude in terms of trying to establish methods that will be more effective in containing costs, but they do not have the kind of latitude that they would like.

And they always feel vulnerable to being sued under the Boren amendment. There are even cases where States that have done good things, had generous rates, and had built-in incentives for cost containment, were sued and had to defend themselves. They won but there was quite a cost in going through the process of being sued and defending yourself, even though you have not done anything wrong.

Chairman KASICH. So it would pour cold water on the ability to negotiate reimbursement schedules that they are happy with. I mean it has a chilling effect, right?

Mr. SCANLON. There is no State that I know of that actually negotiates rates any more. They have all gone to some formula approach to try and be able to build a defense for the Boren amendment.

Chairman KASICH. Would you share in the Governors' views that to repeal the Boren amendment would allow them to have a much more cost-effective program?

Mr. SCANLON. I think they could certainly be more aggressive about their ratesetting, for sure.

Chairman KASICH. Would you agree with me that to repeal the Boren amendment would result in a savings in the area of the reimbursement rates and allow them to more effectively serve their populations?

Mr. SCANLON. I think that would definitely generate a savings, yes, it would.

Chairman KASICH. There you go, that was good.

I just want to conclude by saying that there is an interesting article that I read, and I just want to make a comment. I think this is a very interesting and critical debate and it is about whether we can have faith in States and Governors being able to figure out how to deal with their populations better than we can out of here. And there will be some people who will hold a very legitimate point of view. I respect their point of view that we can better run this program and make sure States do their thing by doing it from top down. There are others that do not share that and I am one of them.

I think that Governors and legislators who live in our communities and you see them all the time, and many of them are out there in the work force, I mean that is a philosophy that we happen to subscribe to—they can do better at that level.

It is clearly going to be a very aggressive debate, I think, as we make our way through the reinvention of the Medicaid program.

Are there other questions of the witnesses?

The gentle lady.

Mrs. MINK. It might startle you to know that this member, at least, is open to the suggestion that the States be granted much larger opportunities to manage and run the Medicaid program. I think that is why my State ventured into the waiver arena because they were interested in achieving 100 percent coverage.

And they felt that only through the use of a waiver in which they would have flexibility in extending the population of people covered, using the same bucks, but not any more than anybody else received per capita, that in contracting out with the private carriers in our State they could, in fact, extend the number of people that were included in their State health care program, which was already in place.

So I think the concepts that you have listed are real and genuine and I think that those of us, on this side of the aisle, will certainly have to pay great heed to it. The one point that I tried to make earlier was the rate of Federal contribution, that is where I think we will have some disagreements, because in my State we feel very strongly that the rate of contribution set at 50 percent in my State, which is the lowest, was not fair.

So in getting into this issue, it is not the concept of greater State control, because we have already ventured into that, but it is the extent to which the Federal Government will retain its equitable share of picking up the costs.

The other element that was raised—I do not know if you have any response to it—was the matter of fairly well-to-do elderly transferring their properties at some point in order to be able to qualify for Medicaid.

Is that a problem that you have investigated, that you find is extant throughout the country, and is there some possibility that we might explore that as a legitimate way of saving costs?

Mr. BOWSHER. Yes. We have done one study on that and there is no question that that goes on. I think that everybody who looks at Medicaid and the elderly going into the nursing homes knows that technique—I do not know how often but you hear it all the time. Talk to anybody at any nursing home and they will tell you those stories.

We would be happy to share our report with you that we did.

Mrs. MINK. That would be wonderful.

Have you reached any value figure of what the savings might be if we narrowed the opportunity for such conveyances?

Mr. BOWSHER. We studied it in a couple of States, but you could not extrapolate the savings.

One thing I might point out to you, Congresswoman Mink, is that, as you know, your State has, really, one of the better health care systems and certainly one of the higher percentages of coverage.

We did a report at the request of the Congress on your State, some time ago. Going into that waiver, I think your State probably has less risk of potential problems, because you had such a high percentage of coverage to begin with.

Mrs. MINK. If I might regain the chairman's attention, one of the real problems——

Chairman KASICH. You have had it all along.

[Laughter.]

Mrs. MINK. One of the real problems we face—the witness just attested to the genuine efforts that my State has made—but one of the real problems is constant difficulty of making the ERISA waiver idea acceptable.

We could not have gotten to anywhere in this health care field without it and there is still this constant threat that that ERISA waiver is going to be removed, and if that happens our whole system and program will collapse.

So I just wanted to make that point that there are these two things that really go together to make it possible for States to venture and take greater control over the health care system for their poor families.

Thank you.

Chairman KASICH. I want to compliment the gentle lady. And I think this example—I mean we heard during the whole health care debate about Hawaii and its progressive. I hope some time to maybe go and have a hands-on examination of exactly what is going on there.

Mrs. MINK. You are invited.

Chairman KASICH. I am never startled. Tonight I am going with Neil Abercrombie to see Leon Russell. He called me out of the blue and I figure it is always good to be friendly with people who live in places like Hawaii. So anyway, Nick Smith has a quick question. I do not know whether John has another one. We have 10 minutes to the vote. We can wrap up this panel and what I intend to do is we are going to go over and vote, and we will get started at about 1:25 p.m. for the next panel. We will keep that panel short and then we can wrap this up today.

The gentleman from Michigan.

Mr. SMITH OF MICHIGAN. Mr. Chairman, this might be a question to you as well as to Mr. Bowsher. That is, how much do you block grant to States? When you see differences—for example Nevada serves 284 people per 1,000 of a certain category of poor; compared to Rhode Island serving 913 per 1,000 at the same level of poverty; and Mississippi spends $2,700 per Medicaid recipient compared to New York spending close to $7,000 per recipient—how do you decide on a block grant? That gives me the most trouble in going to block grants to States.

Do you have a comment?

Chairman KASICH. You know, obviously formula is very important and I think we essentially are going to stay essentially with the formula that we have.

Mr. SMITH OF MICHIGAN. See, the sad part is that block grants tend to penalize those States that have done an exceptional job, discovered ways to reduce costs and applied for waivers to bring that cost down.

Chairman KASICH. I do not think we are in stone necessarily on that, but I would also point out that if you look at Medicare you have significantly lower costs, for example, in Arizona, or in Minnesota, than you have in New York.

And that is a function of the type of system you have. It is a function of what medical care costs are in particular parts of the country. But the gentleman clearly makes a good point, but what I would say is, it does not make sense going into the 21st century for us to continue to try and generate nationwide solutions in 50 entities, all of which have unique approaches, problems, and solutions.

But I think the gentleman makes a good point.

Mr. SMITH OF MICHIGAN. Do you have any comments on that, Mr. Bowsher, you have looked at it?

Mr. BOWSHER. Yes. No, I have no comment on it.

Chairman KASICH. We will stand in recess until about 1:25 and then we will come back at 1:25 and get started.

I want to thank Mr. Bowsher who I think has made a great contribution here today as he always does. And we are proud of the work you do.

Mr. OLVER. Are you dismissing this panel then?

Chairman KASICH. Yes. Did you have another question?

Mr. OLVER. Oh, I sure have questions, but——

Mr. BOWSHER. Why do we not come and meet with you and get together? How would that be? We can do that.

Mr. OLVER. OK, fine, that would be easy.

[Recess.]

Chairman KASICH. The Budget Committee will come to order. And I want to thank the three witnesses. We have got Daniel Anderson, vice president, National Association of Medicaid Fraud Control Units. We have got Tom Kubic, Tony's brother, is that right?

Mr. KUBIC. Yes, sir, I played right field.

Chairman KASICH. And he is the Chief of Financial Crimes Section with the FBI, and, of course, Michael Mangano, the Principal Deputy Inspector General of HHS.

Who wants to go first?

Michael, go ahead.

STATEMENTS OF A PANEL CONSISTING OF MICHAEL MANGANO, PRINCIPAL DEPUTY INSPECTOR GENERAL, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; THOMAS T. KUBIC, CHIEF, FINANCIAL CRIMES SECTION, FEDERAL BUREAU OF INVESTIGATION; AND DANIEL R. ANDERSON, VICE PRESIDENT, NATIONAL ASSOCIATION, MEDICAID FRAUD CONTROL UNITS

Mr. MANGANO. Thank you, very much, Mr. Chairman and members of the committee for giving us this opportunity to testify on the subject of Medicaid fraud and abuse and what is being done to address it.

At your request, I will largely focus my testimony on how the OIG oversees and coordinates the Medicaid fraud control activities through the State Medicaid Fraud Control Units.

These units are funded primarily through Federal grants managed by our office. I will also address some of the functions of the unit and the appropriateness of their level of Federal funding. If you had asked me what is different today from several years ago in the health care fraud enforcement arena, I would give three observations.

First, rising Medicare and Medicaid expenditures create a more attractive target for the unscrupulous. Second, fraud schemes are demonstrating increasing sophistication and complexity; and third, inadequate resources are available to address the problem of health care fraud and abuse.

Medicaid expenditures, as we have heard earlier today, have risen dramatically in recent years. The Federal share in Medicaid outlays has grown from $41 billion in 1990 to an estimated $88 billion this year, more than doubling in 5 years. The health care fraud environment today involves complicated reimbursement issues, medical questions, financial arrangements, often intricate schemes with groups of perpetrators and large dollar amounts.

The size and complexity of these cases demand increasing resources dedicated to fighting health care fraud and abuse. Despite increased demands, however, the OIG staff has declined about 15 percent in the last 3½ years.

Although the OIG resources are not a topic of the hearing, I mention the downsizing to emphasize the importance of working cooperatively with other enforcement groups to achieve our common objectives.

Fortunately, the OIG is able to leverage its investigative resources for Medicaid through the State Medicaid Fraud Control Units. The State units operate totally separate and apart from the single State Medicaid agency and are usually located in the State attorney general's office.

They are specially trained to investigate and prosecute complex Medicaid provider fraud and violations of State laws pertaining to the Medicaid program. The units are also required to——

Chairman KASICH. Michael, you are not going to read this whole thing, are you?

Mr. MANGANO. I had about 4 minutes, but I will not read it any more.

Chairman KASICH. What I would ask you to do and you can read it, if you want to. I would ask the other two gentlemen, tell us what you think here. Take as long as you want.

Mr. MANGANO. I would say the level of fraud and abuse that is out there today in the arena, with Medicaid and Medicare and others, has not been anywhere near what it needs to be in the last few years, in fact, it is growing.

We also have a problem of declining resources in all three of the organizations that are represented at this table today. What we really need is to have a greater emphasis on attacking these kinds of problems through a coordinated effort. I think we have made substantial gains with all three of these organizations. At the Federal level we do a lot of coordination with the Department of Justice and the other law enforcement organizations and we work very closely with the State Medicaid Fraud Control Units to bring that about.

The kinds of schemes that are out there in Medicaid are exactly similar to those we see in the Medicare arena with false billings, billings for services that are not rendered, misrepresentation and the like. Unfortunately, I am here to tell you that the people that are committing crimes against our programs are winning the war against fraud and abuse. And they are winning the war because they have got sophisticated techniques; they have got wide-ranging networks.

In the past, 15 years ago, the simple case that we would get involved with was a provider that was billing for services that they did not provide. Today, we are dealing with complex schemes. One of the examples I used in the written testimony was the National Medical Enterprise investigation that involved all three of us. The settlement on that case was $379 million returned to the Federal and the State government, the largest health care fraud settlement achieved in government.

The scheme was there was a national conglomerate of psychiatric and drug-abuse hospitals, 60 hospitals across 30 States, paying kickbacks to doctors and other providers for referring their patients to these facilities. And, of course, the patients came into the facilities, and their time lasted just long enough until the insurance ran out.

The only good part of this story is that we caught them through a lot of effort from the FBI, the State Medicaid Fraud Control Units, and our offices and others. We brought them to justice and they paid $379 million.

Those are the kinds of schemes that we are looking today, very complicated and that is what we would like to focus your attention on today.

[The prepared statement of Michael Mangano follows:]

PREPARED STATEMENT OF MICHAEL MANGANO, PRINCIPAL DEPUTY INSPECTOR GENERAL, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

INTRODUCTION

Good morning Mr. Chairman and members of the committee. I am Michael Mangano, Principal Deputy Inspector General of the U.S. Department of Health and Human Services. Thank you for giving us the opportunity to testify on the subject of Medicaid fraud and abuse and what is being done to address it.

Mr. Chairman, we very much appreciate your interest in the issue of health care fraud and abuse—a problem which squanders our limited governmental resources and which can adversely affect the health and safety of the people Medicaid is intended to assist. At a time when various health care cost savings are being considered by Congress, it is appropriate that we discuss fraud and abuse in order to assure that our federally funded health care programs operate efficiently, economically, and effectively. Also, it is important that any changes in our financing and delivery systems be made in a manner consistent with minimizing the potential for fraud, waste, and abuse.

At the outset, let me stress that fraud against health care programs, including Medicaid, is being fought on many fronts: 10 years ago, the OIG helped establish the National Health Care Anti-Fraud Association—representing both governmental and private third-party payers and law enforcement agencies—to coordinate governmental and private health care fraud enforcement activities. Over the years, this governmental/private partnership group has been extremely successful in fostering collaboration.

Moreover, the OIG has recently established with the Department of Justice and other enforcement agencies an executive level working group to focus on health care fraud, and we have started to see positive results. We are continuously striving for even better communication and coordination of law enforcement activities in the fight against health care fraud and abuse.

At your request, I will largely focus my testimony on how the OIG oversees and coordinates Medicaid fraud control activities through the State Medicaid Fraud Control Units. These units are funded primarily through Federal grants managed by our office. I will address some accomplishments of the units and the appropriateness of their level of Federal funding later in my testimony.

THE OFFICE OF INSPECTOR GENERAL

By way of background, the Office of Inspector General [OIG] was created in 1976, and is statutorily charged with protecting the integrity of departmental programs, as well as promoting their economy, efficiency, and effectiveness. The OIG meets this statutory mandate through a comprehensive program of audits, program evaluations, and investigations designed to improve the management of the Department and to protect its programs and beneficiaries from fraud, waste, and abuse. Our role is to detect and prevent fraud and abuse, and to ensure that beneficiaries receive high quality, necessary services, at appropriate payment levels.

Within the Department, the OIG is an independent organization, reporting to the Secretary and communicating directly with the Congress on significant matters. We perform our mission through a field structure of 8 regional and more than 60 field offices, staffed by auditors, evaluators, and investigators.

In fiscal year 1994, we were responsible for 1,169 successful criminal prosecutions and 1,334 administrative sanctions imposed against individuals and entities that defrauded or abused the Department's programs and/or beneficiaries. Last year, the OIG also generated savings, fines, restitutions, penalties, and receivables of over $8 billion. This represents $80 in savings for every Federal dollar invested in our office, or $6.4 million in savings per OIG employee.

CURRENT CHALLENGES

If you were to ask what is different today from several years ago in the health care fraud enforcement arena, I would make three observations:

Rising Medicare and Medicaid expenditures create a more attractive target for the unscrupulous;

Fraud schemes are demonstrating increased sophistication and complexity; and

Inadequate resources are available to address the problem of health care fraud and abuse.

The Medicaid program provides grants to States for medical care for approximately 36 million low-income people. While there are specific Medicaid requirements, States have considerable flexibility in structuring their Medicaid programs, including provider payment rates, certifications standards, and developing alternative health care delivery programs. In addition, waivers from various portions of the broad Federal guidelines are also available to States.

Medicaid outlays have risen at a dramatic pace, causing Medicaid spending to become the fastest rising portion of both the Federal and State budgets. The Federal grant is open-ended, paying from 50 to 83 percent of the State's Medicaid expenditures, based on a calculation of the State's relative wealth. The Federal matching rate on average is approximately 57 percent.

From fiscal years 1989 through 1992, Medicaid grew at a 25-percent average annual rate. However, outlay growth slowed to less than 12 percent in 1993, followed by 8 percent growth in 1994. The decline in the rate of increases is due to many factors, including legislative changes—such as limits on provider specific taxes and donations—decreases in the projected growth of SSI caseloads, and States' efforts to control costs. Nevertheless, we have arrived at a new threshold of spending. In 1990, total Medicaid outlays—vendor payments, premiums, and administrative costs—exceeded $72 billion. The Federal share of that was almost $41 billion. We expect the Federal share of Medicaid will be over $88 billion in fiscal year 1995. The cost of Medicaid to Federal taxpayers has more than doubled in 5 years.

We see a trend toward increased complexity and sophistication in the various schemes used to defraud the Medicare and Medicaid programs. When we first started investigating health care fraud almost 20 years ago, we were primarily seeing instances of individual providers filing false claims for relatively low dollar amounts. Today, we see increasingly complex fraud schemes involving groups of perpetrators and large dollar amounts. The health care fraud environment today involves complicated reimbursement issues, medical questions, and financial arrangements. The size and complexity of these cases demand increased resources dedicated to fighting health care fraud and abuse.

Despite increased demands, the OIG's investigative and audit resources have declined in the past several years, from 1,411 employees in 1991 to 1,207 employees in 1995. By the end of fiscal year 1994, 11 OIG investigative offices in 10 States

and Puerto Rico were closed. During the same period, the OIG was required to implement the financial statement audit provisions of the Chief Financial Officer's Act of 1990, other new audit responsibilities, as well as 32 new civil monetary and exclusion authorities, without any additional funding for these new responsibilities. Our next challenge will be to adapt to the transfer of 259 staff members to the Office of Inspector General in the new Social Security Administration at the beginning of this month. We intend to close 6 more investigative offices.

Funding for OIG activities has also been hampered by the discretionary freeze provisions of the Budget Enforcement Act. Budget constraints have produced the illogical result that spending on fraud prevention and detection—activities that pay for themselves many times over—has actually been curtailed. New resources are needed to fight burgeoning health care fraud and abuse.

Although OIG resources are not the topic of this hearing, I mention the constraints to emphasize the importance of working cooperatively with other enforcement groups to achieve our common objectives. Fortunately, the OIG is able to leverage its investigative resources for Medicare through coordination with the Health Care Financing Administration's contractor-based fraud units and, for Medicaid, through the State Medicaid Fraud Control Units. We appreciate this opportunity to highlight the State network and its contributions.

MEDICAID FRAUD CONTROL UNITS

The HHS OIG is responsible for fighting fraud in all HHS programs. While we do investigate Medicaid fraud directly, most activity and convictions are achieved through the Medicaid Fraud Control Units whose funding and quality standards we oversee. We work with the units on joint cases, train staff, and provide general oversight from a national perspective. Over time, these units have developed in a positive direction and are becoming very effective in identifying and prosecuting health care fraud in their States.

The State fraud control units operate totally separate and apart from the single State Medicaid agency and are usually located in the State attorney general's office. The units are staffed by professional teams of attorneys, investigators, and auditors specially trained in the complex litigation of health care fraud. During fiscal year 1994, the units obtained 683 convictions, and recovered over $36 million in fines, restitution, and overpayments. In addition, in 1994 the Office of Inspector General obtained convictions in 48 Medicaid-related cases. In 7 of these cases we conducted joint investigations with the States. The 45 States with certified units cover about 97 percent of all Medicaid health care provider payments.

The legislation implementing the State units in 1977 (Public Law 95–142) provided enhanced Federal financial participation for States to establish and operate fraud control units certified—and annually recertified—by the Secretary of Health and Human Services, as meeting various statutory requirements. The State Medicaid Fraud Control Units are federally funded State law enforcement units which investigate and prosecute Medicaid provider fraud and violations of State laws pertaining to fraud in the administration of the Medicaid program. The units are required to review complaints of patient abuse and neglect in all residential health care facilities that receive Medicaid funds, particularly nursing homes. These people are some of the most vulnerable citizens in our population.

A provision of the Omnibus Budget Reconciliation Act of 1993 requires all States to have units unless they get a waiver approved by the Secretary. There are currently 45 certified units staffed by approximately 850 attorneys, auditors, and investigators. The units range in size from 3 to more than 230 professional staff. If we exclude the smallest unit and largest unit, the average size for the other State units is about 15 professional staff. We have approved two States waivers; a third State waiver is pending; and two States are seeking matching funds from their legislatures. Since the inception of the Medicaid Fraud Program in 1978, the units have successfully prosecuted over 7,000 cases and have been responsible for identifying and returning hundreds of millions of program dollars.

Some of the types of fraud schemes currently being investigated by the units involve: billing for services not provided; double billing; providing unnecessary services; misrepresenting services provided; illegal remunerations; and false cost reports. I will explain each of these types briefly.

Billing for services not provided.—This is one of the most common types of fraud. Examples include a provider who bills Medicaid for a treatment or procedure which was not actually performed, such as blood tests when no samples were drawn, x rays which were not taken, or in the case of a dentist, billing for a full denture plate when only a partial was supplied.

uble billing.—A provider will bill both the Medicaid Program and a private insurance company—or the recipient—for the treatment. Also, two providers could request payment for services rendered to one recipient for the same procedure on the same date.

Providing unnecessary services.—A provider may misrepresent the diagnosis and symptoms on recipient records and billing invoices to obtain payment for unnecessary tests and procedures.

Misrepresenting services provided.—A pharmacy may bill the program for the cost of a prescription drug charging the name brand prescription drug price, when a generic substitute was supplied to the recipient at a substantially lower cost to the pharmacy. Less expensive goods may be supplied to a patient, then a higher priced item is billed to Medicaid.

Illegal remunerations.—A provider, that is, a nursing home operator, may conspire with another health care provider—physician, laboratory, pharmacy, ambulance company—to share (kick back) a certain portion of the monetary reimbursement the health care provider receives for services rendered to patients. Kickbacks include vacation trips, automobiles, or other items. The practice results in unnecessary tests and services being performed for the purpose of generating additional income to the referring provider.

False cost reports.—A nursing home owner or hospital administrator may include inappropriate expenses in claims to Medicaid. These expenses include the costs of items for personal use.

Health care providers currently under investigation are: nursing facilities; hospitals; doctors; dentists; chiropractors; podiatrists; ophthalmologists; pharmacies; durable medical equipment vendors; medical laboratories; transportation companies; and home health agencies. The units have accumulated vast experienced in these white-collar crime cases that would be difficult to duplicate or replace.

In addition to pursuing Medicaid-specific fraud, units have undertaken initiatives in several health care areas and have been involved in joint prosecutions with Federal agencies. I would like to highlight some examples in which State units assisted our office and other Federal agencies in large scale or crosscutting efforts.

National Medical Enterprises.—In the largest health care settlement in history, a record $379 million in criminal fines, civil damages and penalties, and program restitutions was settled with National Medical Enterprises, Inc., for kickbacks and fraud at NME psychiatric and substance abuse hospitals in more than 30 States. The company operated 60 such hospitals across the country and, among other offenses, paid kickbacks to induce doctors and other professionals to refer Medicare and Medicaid patients to the hospitals. This case resulted from one of the most extensive multiagency enforcement operations ever undertaken by the U.S. Government. Federal agencies included the Justice Department, the Federal Bureau of Investigation, the Defense Criminal Investigative Service, the U.S. Postal Inspection Service, the Internal Revenue Service, and the HHS Office of Inspector General. Several State units also participated in the investigation. As part of the settlement, NME agreed to pay $16.3 million to several States for harm caused the State-funded portion of Medicaid and other State health programs.

Operation Goldpill.—Operation Goldpill was a long-term undercover investigation in which a task force of Federal and State agencies worked together effectively for almost 4 years to combat drug diversion. Drug diversion is a practice in which pharmacists buy drugs from street dealers for repackaging and resale to the unsuspecting public. Under a complex scheme, medical professionals and their accomplices stole tens of millions of dollars from Medicaid as prescriptions were falsified or resold. Simpler versions of the fraud included billing Medicaid for prescriptions that were never filled or substituting cheaper generic drugs while billing Medicaid for higher-priced alternatives. The operation did a brisk business in reselling. A physician would prescribe medicine for a healthy Medicaid eligible who would fill the prescription at a crooked pharmacy. The patient would then sell the medicine for about 10 percent of its value to a diverter who would repackage and resell it to another pharmacy at a steep discount. This joint Federal and State investigation, which included (among others) the Federal Bureau of Investigation, State Medicaid investigators, and our office, resulted in arrests in over 50 cities across the country.

SSI program abuse.—State unit activities often reveal abuses in other programs. It is common that the State units, in investigating Medicaid matters, uncover abuses in other health programs both in the private and public sectors. I want to mention one situation in which they also uncovered abusive activities in a nonhealth program—the Supplemental Security Income program [SSI]. Investigators in the Bureau of Medi-Cal Fraud—California's Medicaid fraud unit—discovered that unscrupulous physicians were providing false medical evidence enabling individuals to become eligible for SSI and, subsequently, Medicaid. Although the assistant U.S. at-

torney for the central judicial district of California determined there were no prosecutable charges under Medicaid, our office was able to use the information to correct a problem area in the SSI program. As a result of our investigation, the names of over 500 suspect SSI recipients were forwarded to the Social Security Administration for review. As a result, 58 recipients have been removed from the SSI roles with a program savings of at least $418,000.

National Health Laboratories, Inc.—The NHL case involved an extensive 2-year Federal grand jury investigation assisted by the FBI, the Defense Criminal Investigative Service, California Medi-Cal, and various other State units, and auditors and investigators from our office. The NHL is a major California blood-testing laboratory which submitted false claims to the government and agreed to repay $110 million in a global civil settlement. The scheme involved including extraneous tests in a series of blood tests doctors order frequently. The tests were improperly billed in a way that resulted in millions of dollars in losses to Medicare, Medicaid, and CHAMPUS. This investigation is one more significant example of how Federal and State agencies work in concert to successfully curb large-scale fraud.

The State units are an integral part of the fight against fraud and abuse in the Nation's health care delivery system. As the Federal oversight agency for the units, we continue to support their efforts, and work jointly with them whenever possible.

As Medicaid watchdogs, the units are providing invaluable service to the taxpayers and the Medicaid-eligible poor and disabled people of their States. While many State-level convictions do result in substantial recoveries, many others are largely humanitarian and protective in nature. For example:

Managed care.—Units are actively monitoring developments in managed care programs. States are starting to require numbers of their Medicaid population to participate in managed care programs. While the traditional Medicaid provider fraud investigation focuses on overutilization of services and fraudulent billing and seeks accountability for claimed services, in managed care investigations, there is the possibility of underutilization of services. Unlike the typical Medicaid provider fraud case, there may be reduced access to quality care, and the delivery of substandard and generally inappropriate health care. We recognize that managed care is a different environment than traditional fee-for-service plans. There are substantial differences in billing and reimbursement and in how service is provided. We are also watching for intentionally misleading recruitment activities where people do not really understand that the plan they have signed up for is very different from fee-for-service. Currently, about 8 million people—almost 25 percent of all Medicaid recipients—are enrolled in managed care arrangements.

Patient abuse.—As of December 31, 1994, the units had over 4,100 open investigations, of which over 1,200 concerned patient abuse and neglect. Patient abuse cases currently account for over 28 percent of all caseloads. These cases must be done to protect the elderly and severely disabled, and they return little or no monetary restitution to the program. For example, in Delaware an attendant restrained a confused 79-year-old resident with Parkinson's disease because she did not want to sit in a wheelchair and struck her when she struggled to get up. In Maryland, an angry nurse aid yanked an 86-year-old patient with severe dementia out of her wheelchair and threw her to the floor. In Tennessee an attendant sprayed an 82-year-old victim's face with a shower head for an extended period of time and hit him with a wet towel. There are also numerous instances of sexual and emotional abuse of seriously ill patients. In considering the return on investment of the units, we must keep in mind that although patient abuse cases do not contribute greatly to the monetary achievements of the units, prosecuting these cases is a critical, essential service for which we should continue to devote resources.

OIG OVERSIGHT OF STATE UNITS

The State Fraud Branch of the OIG's Office of Investigations is responsible for the oversight of the 45 State units including coordinating part of their investigative training.

During fiscal years 1993–1995, the Office of Inspector General in coordination with the Health Care Financing Administration has funded training for over 170 employees of the State Medicaid Fraud Control Units at a cost of approximately $120,000. Five week-long training sessions have been held, or are planned, at the Federal Law Enforcement Training Center at Glynco, GA, for investigators of the State units. The training is intended to improve the effectiveness of the State units in investigating and prosecuting instances of alleged Medicaid provider fraud and instances of patient abuse and neglect. The training includes topics such as Medicaid fraud schemes, interviewing, evidence, preparing cases, and basic accounting ap-

plications. We consider such training to be of direct benefit to the Medicaid program.

Our oversight duties include the initial certification and yearly recertification of the units. Regulations require the units to submit a reapplication to the OIG each year including an annual report and a budget request. The unit's reapplication reports and annual report, as well as quarterly statistical reports submitted by the units, Medicaid agency questionnaire responses, and OIG field office questionnaire responses, are reviewed to determine if the units are effectively and efficiently carrying out their duties in combating Medicaid fraud and patient abuse, and are in conformance with performance standards issued by the Office of Inspector General. We maintain ongoing communication with individual State units and the National Association of Medicaid Fraud Control Units concerning interpretation of program regulations, congressional requests, and other policy issues.

RECOMMENDATIONS

State unit funding.—We believe that expenditures to assure the development and continued operation of State Medicaid Fraud Units constitute an effective use of Federal funds.

The Congress originally provided that units would be federally reimbursed for 90 percent of their startup and operating costs. That original funding authority was for 3 years, at the end of which the funding mechanism was changed by the Omnibus Budget Reconciliation Act of 1980 (OBRA '80). The OBRA '80 legislation substituted a Federal matching arrangement of 90 percent for a 3-year period, and 75 percent thereafter. The Federal share of operating the units is expected to be about $70 million for this fiscal year. Last year, the States matched $64.5 million in Federal funding with almost $21 million in State funds.

The National Association of Medicaid Fraud Control Units has indicated that without a continuation of the current Federal matching rate, some existing units would cease operation, and other States would have to drastically cut back on personnel due to their States' fiscal constraints and budget cuts.

Any units that are downsized would be much less effective, and the State Medicaid agencies would be forced to absorb additional antifraud activities into their already numerous functions. This would result in a loss of efficient criminal investigation and prosecution activities for which the current Medicaid Fraud Control Units are better suited. In States where it would not be possible to increase the matching contribution, there would be an inevitable loss of professional staff in these units.

Because of our own resource shortages, the OIG is not able to provide an investigative presence in many States. We rely on the State units as our first line of defense in those areas against the spread of Medicaid fraud. Their prosecutions are carried forward under more expeditious State laws. Therefore, we would not support a reduced rate of Federal matching funds for the State units.

Better communication.—Clearly, if we are to maximize our resources in fighting health care fraud and abuse, we need to enhance communication between Federal and State law enforcement agencies, as well as Federal and private third-party payers. It is important that Federal, State, and local governments, as well as third-party payers, communicate with one another with respect to sanctioned providers. For example, we support the establishment of a central repository for the reporting of final adverse actions taken against health care providers which would permit Federal, State, and private payers to become aware of and take reciprocal actions to sanction health care providers who abuse or defraud health care financing programs. We would suggest that this data bank also be made available to the public so that beneficiaries can be informed and vigilant about health care providers and practitioners they utilize. We generally support proposals similar to those introduced in the Senate this session by Senator Cohen.

MEDICAID SAVINGS

Some unnecessary costs to the Medicaid program come not from fraud or abuse but from policy decisions. I want to describe some recommendations from our OIG audit and evaluation work that could generate savings in the Medicaid program. Alter the hearing, I will provide the members of the committee the 1995 edition of the Office of Inspector General "Cost-Saver Handbook," also known as the Red Book, which contains unimplemented OIG recommendations that result in cost savings. We estimate that these recommendations could save $25 billion annually and another $1 billion in one-time recoveries. These legislative, regulatory, and administrative options could be considered by policymakers to attain greater program efficiency and to enhance the viability of the trust funds. I would like to describe a few items that relate to the Medicaid program.

Medicaid cost sharing.—While 27 States use some type of cost sharing in their Medicaid programs, these States did not report excessive administrative, recipient, or provider burdens. We recommended that HCFA promote the development of effective cost sharing programs and estimated that savings in excess of $120 million annually could be attained—and $768 million over 5 years.

Medicaid payments to institutions for mentally retarded people.—The OIG has found that Medicaid reimbursement rates for large institutions are more than five times greater in some States than in others—ranging from $27,000 to $158,000 annually per resident. We outlined a number of different options for controlling excessive spending for these services and estimated that savings in excess of $680 million could be attained annually—and $3.4 billion over 5 years.

Medicaid generic drugs.—We have also recommended that HCFA identify and alert States to methods which would encourage the use of lower-priced generic drug products in the Medicaid program. We found that annual cost savings to the Medicaid program could be as much as $46 million for only 37 high-volume dispensed brand name drugs, if the reimbursement for those drugs was limited to the amounts set by HCFA for equivalent generic drugs—and $245 million over 5 years. Cost savings would become even greater in the future as the Federal patents on exclusive drug manufacturing of 60 important, highly used drugs with more than $10 billion in sales will expire by the end of the year. We recommended that HCFA identify and alert States to methods which would encourage the use of lower-priced generic drug products in the Medicaid program.

FEDERAL/STATE AUDIT PARTNERSHIP

As the Medicaid program experiences a tremendous rate of growth, innovative actions are needed to help achieve the mission of the Office of Inspector General. One such action has been to form a partnership between the OIG, HCFA, and State auditors and evaluators to undertake joint projects for improvement of the program. These projects are intended to produce mutually beneficial results and savings at both the Federal and State levels. The partnerships work in three different ways: first, initiating joint projects where OIG and State auditors work with mutually beneficial results; second, the OIG sharing the methods and results of its earlier Medicare and Medicaid projects to provide State auditors with leads for cost savers; and third, the OIG using States' experiences to estimate the national impact of successful recommendations implemented at the State level. To date, we have completed several reviews with the States involving Medicaid drug issues and have initiated additional reviews involving drugs, payments for laboratory services, hospital transfers, and nonphysician services prior to inpatient hospitalization.

CONCLUSION

As the Congress contemplates changes in our health care system, the problems of fraud, waste, and abuse must be addressed. We stand ready to work with you on these issues.

Chairman KASICH. Very interesting. Mr. Kubic.

STATEMENT OF THOMAS T. KUBIC

Mr. KUBIC. Thank you, Mr. Chairman, and members of the committee. Good afternoon, and for the record, I also brought along a copy of Director Freeh's testimony that he gave before Senator Cohen's committee a couple of weeks ago. I think that the committee and the Chair would find it enlightening, because what that does is, in essence, define a much broader problem than your particular focus, here, today.

[The prepared statements of Louis J. Freeh follows:]

PREPARED SHORT STATEMENT OF LOUIS J. FREEH, DIRECTOR, FEDERAL BUREAU OF INVESTIGATION, BEFORE THE SPECIAL COMMITTEE ON AGING, U.S. SENATE, MARCH 21, 1995

Good morning Mr. Chairman and members of the committee.

I appreciate the opportunity to testify today as this committee begins hearings on one of the most significant crime problems of this decade. I am referring to health care fraud, a problem so significant that it directly impacts one-seventh of this Nation's economy—the health care system. I applaud your determination to pass new

laws that will help combat burgeoning health care crime. Law enforcement has neither the resources nor the special legal tools applicable to health care fraud it needs to be fully effective.

There is much to be done if we wish to curb rampant fraudulent activity in the $884 billion health care industry. Conservative estimates put the annual losses associated with health care fraud at $44 billion. It is obvious that these losses are recouped from taxpayers through higher taxes and higher health insurance premiums. If stronger laws are enacted, millions, if not billions, of dollars can be saved.

Before I address some of the problems we face in investigating health care fraud, I must emphasize that my comments are not intended to be an indictment of the entire health care industry.

Without question, a large percentage of health care professionals and businesses provide quality medical treatment and bill honestly for their services. Sadly, today's honest health care professional must coexist in a complex business environment permeated by professional con men and thieves. The medical community should not have to endure the taint these criminals bring to a profession dedicated to healing the sick and saving lives.

Regrettably, however, there is a serious problem that has grown dramatically in the last few years. Organized criminal enterprises have penetrated virtually every legitimate segment of the health care industry. By way of example:

In south Florida and southern California, we have seen cocaine distributors switch from drug dealing to health care fraud schemes. The reason—the risks of being caught and imprisoned are less. Drug dealers who are committing health care fraud know that they likely will face only minor punishments because law enforcement is not yet equipped with the laws needed to effectively attack this problem.

In the Pacific Northwest we have seen broker-translators who have extorted kickbacks from recent immigrants and have paid bribes to State employees in the welfare department. The immigrants become falsely certified as medically disabled to begin receiving long-term Social Security benefits. The same immigrants become eligible for Medicaid and food stamp benefits. In one case, the losses in the Social Security, Medicaid, and the food stamp program are in the hundreds of millions of dollars.

We have also identified cases where nursing home and hospice operators have exploited elderly and Alzheimer's patients by fraudulently billing for services, incontinence supplies, and medications. Tragically, the patients they prey on often have difficulty understanding they are being victimized by these illegal activities, and are unable to alert law enforcement to the problem.

Throughout the United States organized criminal groups have compromised doctors, chiropractors, and attorneys. These groups establish storefront clinics, diagnostic testing companies, and bogus law offices. They stage phony car accidents. Fake patients visit the clinics where expensive medical procedures like MRI's and x rays are billed to insurers even though not provided to the persons posing as patients. In addition, unfilled prescriptions are billed, kickbacks are paid, and lawyers collect false personal injury claims. In some of these cases, witnesses have been extorted and physically intimidated. These schemes have resulted in tens of billions of dollars in losses to insurers and increased premiums to policyholders.

The list of fraud schemes is infinite.

No segment of the health care system is immune.

The FBI has long recognized that the problem is serious and is growing rapidly. It impacts on our citizens' welfare and on our economy. Although the FBI's health care fraud initiative is a top national priority, we are able to address only the tip of the iceberg because of a lack of personnel.

Presently, the FBI has only 249 agents funded to work health care cases. That is up from 97 in 1992. Many of these agents have been diverted from other programs.

Last year, the FBI achieved 353 criminal convictions and obtained $480 million in fines, recoveries, and restitutions and an additional $32.7 million in proceeds were seized or forfeited to the government. In health care investigations, the FBI returns real dollars to victims of fraud and the U.S. Treasury. In 1994, the FBI returned $13.65 in fines, recoveries, restitutions, and forfeitures for every $1 we spent.

A large percentage of our investigations are being conducted jointly with other agencies, and most of our field offices are engaged in one or more health care fraud task forces or working groups. In the near future, the FBI and HHS inspector general will exchange agents at headquarters level in order to better identify and address crime problems, as well as coordinate our joint investigations. The FBI also has regular and productive contacts with State and local agencies and the insurance industry, including groups such as the National Health Care Antifraud Association and the National Insurance Crime Bureau. We have reached out to professional or-

ganizations such as the American Medical Association and the Federation of Chiropractic Licensing Boards. Each of these organizations brings essential skills and knowledge to our enforcement efforts.

The FBI's health care caseload has increased to over 1,500 pending matters, a 142-percent increase in only 2 years. However, there are still many significant cases we have not been able to address.

We are doing what we can with our resources. However, I believe the FBI could have a greater impact on health care fraud if current Federal law was strengthened and if law enforcement was given the tools necessary to attack the problem. Let me describe to you an example of a case that will be difficult to prosecute federally because Federal laws covering the scheme are unclear.

In a recent case, a representative from a medical diagnostic company paid kickbacks to chiropractors for x rays and full body studies which included thermography tests, nerve conduction tests, and MRI tests. The businessman billed private insurers between $1,500 and $4,000 for each patient tested. He paid kickbacks ranging from $100 and $350 per test to approximately 20 chiropractors. Investigation determined that the kickback incentives often controlled medical judgment. This case will not be prosecuted even though huge sums of money were involved since the kickback activity is not covered by Federal law. No Medicare patients were being tested by the businessman. In fact, he took great care not to test Medicare patients, knowing that testing those patients in return for paying a kickback would violate a Federal law. There are no existing or proposed Federal laws that cover this scheme. Similar kickback scenarios are common throughout the industry.

The health care system is increasingly being infiltrated by corrupt criminal enterprises. Presently, use of the *Rico* statute in health care prosecutions is only possible when money laundering, drug, and mail or wire fraud violations are used as predicate acts. The judicious use of *Rico* with other similar criminal enterprises has proven to be a more straightforward and very successful approach that sends a clear message that Congress is serious about a particular crime problem.

The FBI has also found that many of the criminal organizations involved in health care fraud are made up of individuals who represent social or cultural groups which are difficult to penetrate through informants or traditional law enforcement techniques. One tool useful in these types of cases is the court authorized wiretap. However, Federal wiretap law is usually unavailable because health care offenses are not predicate acts to the wiretap investigative technique.

In many respects health care fraud is an evolving and newly developing phenomenon. The traditional statutes like mail and wire fraud do not work well. Criminals have developed schemes specifically designed to avoid these violations. There are a number of potential legal weapons not available to us. For example, there is not a specific health care fraud statute aimed directly at the problem. The current and proposed kickback statutes do not include all payors. Certain health care fraud schemes are not covered under money laundering statutes. Civil penalties do not encompass private payors and Federal grand jury secrecy laws often impede important parallel civil investigations. Proceeds from most health care schemes cannot be criminally seized, frozen, or forfeited.

CONCLUSION

During the eighties, the country suffered through major crime problems including illicit drug trafficking, the savings and loan crisis, defense procurement corruption, organized crime syndicates, securities scandals, and violent criminal gangs. When confronted with those crises, Congress passed tougher bank fraud laws, forfeiture laws, drug laws, money laundering laws, and other statutes.

Health care fraud is now equally grave. Fraudulent activity in the Nation's health care system—one-seventh of our economy—is on the rise. Today, we see cocaine dealers turning into health care fraud entrepreneurs. The Russian Mafia as well as other organized crime groups are engaged in creative schemes to siphon money from government and private health care trust funds.

The FBI will continue to place a high priority on this important work. But maximum progress can be made only if Congress creates needed legislation and provides the personnel and resources to sharply expand tough enforcement activities.

PREPARED STATEMENT OF LOUIS J. FREEH, DIRECTOR, FEDERAL BUREAU OF INVESTIGATION, BEFORE THE SPECIAL COMMITTEE ON AGING, U.S. SENATE, MARCH 21, 1995

Good morning, Mr. Chairman and members of the committee.

Today this committee begins hearings on a crime problem so significant that it affects one-seventh of this Nation's economy—the health care system. I applaud

your foresight in holding this hearing. I also am committed to working with you and Congress to ensure that law enforcement has the tools that are needed to combat the burgeoning health care crime crisis. During the past few years, the FBI has made an increasing effort to combat health care fraud.

By conservative estimates, fraud in the health care system costs $44 billion annually. At present, the FBI has 249 agents funded to health care investigations. Last year, the FBI achieved 353 criminal convictions and recovered $480 million in fines, recoveries, and restitutions, in addition to $32.7 million in proceeds that were seized or forfeited to the government. While these accomplishments are significant, the crime problem is so big and so diverse that we are making only a small dent in addressing the fraud.

More resources and legal tools are needed if law enforcement is to make greater headway in curbing the fraudulent activity involved in the $884 billion per year health care industry. If not, insurance costs to policyholders will continue to skyrocket. Today, I want to talk about the changing faces of the health care criminal and describe to the committee the criminal enterprises that plague our Nation's health care system.

At the outset, I would like to note that a large percentage of health care professionals and businesses provide quality medical treatment and bill honestly for their services. Sadly, today's honest health care professionals must coexist with professional con men and thieves in a complex business environment. The medical community is forced to endure the taint these criminals bring to a profession dedicated to healing the sick and saving lives.

During the past 5 years, the law enforcement community has encountered some investigative as well as prosecutive hurdles in trying to address these cases. We hope that Congress will examine the need for new criminal enforcement and investigative tools.

Schemes crafted by health care criminals have changed dramatically in the past few years. Indeed, organized criminal enterprises have penetrated virtually every legitimate segment of the health care industry. Some examples of their schemes include:

In south Florida and southern California, we have seen cocaine distributors switch from drug dealing to health care fraud schemes. The reason—the risks of being caught and imprisoned are less. Drug dealers who are committing health care fraud know that they likely will face only minor punishments because law enforcement is not yet equipped with the laws needed to effectively attack this problem.

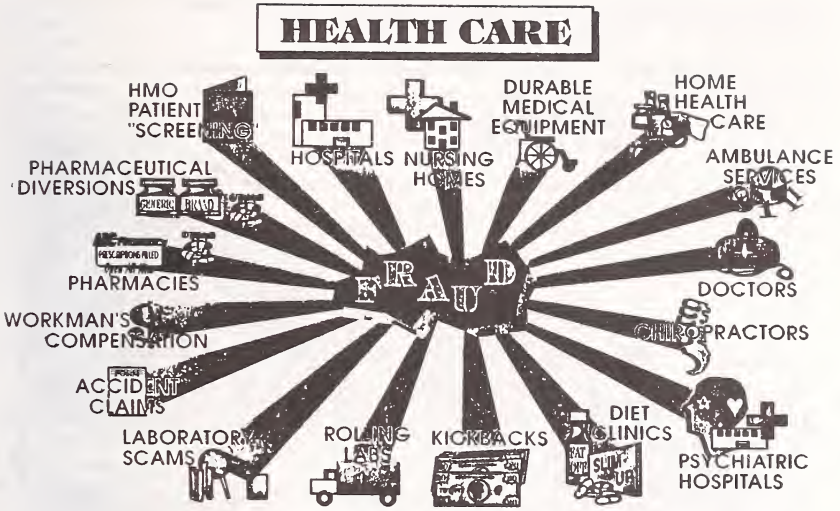
Throughout the United States, organized criminal groups have compromised doctors, chiropractors, and attorneys. These groups establish storefront clinics, diagnostic testing companies, and bogus law offices. They stage phony car accidents. As part of the scheme, phony patients visit the clinics, generating bills for exaggerated medical procedures that are provided. These include unnecessary tests for MRI's, xrays, and other sophisticated tests which are performed and billed to insurers. In some cases, bills are submitted when no medical treatments were even administered. The bogus law offices then collect personal injury claims. Further, these groups have extorted and physically intimidated witnesses. Their schemes have resulted in billions of dollars in losses to insurers and increased premiums to policyholders. In fact, the National Insurance Crime Bureau reports that the average household pays $200 a year in added auto insurance premiums due to fraud.

In the Pacific Northwest, "broker-translators" have extorted kickbacks from immigrants and paid bribes to State employees in the welfare department. The immigrants, who are certified medically disabled, begin receiving long-term Social Security benefits. The same immigrants have become eligible for Medicaid and food stamp benefits. In one case, losses to Social Security, Medicaid, and the food stamp program are in the hundreds of millions of dollars.

We have seen national health care corporations engaging in criminal billing schemes to increase profits. Losses from fraud in these cases are in the billions of dollars.

Throughout the United States, medical institutions working illicitly through "brokers" are paying kickbacks to medical professionals and others responsible for referring chemically dependent and depressed patients to their facilities.

Nursing home and hospice operators exploit the elderly and Alzheimer's patients by fraudulently billing for services, incontinence supplies, and medications. Tragically, criminals prey on patients who have difficulty understanding or remembering these illegal activities, much less alerting law enforcement about the problem.



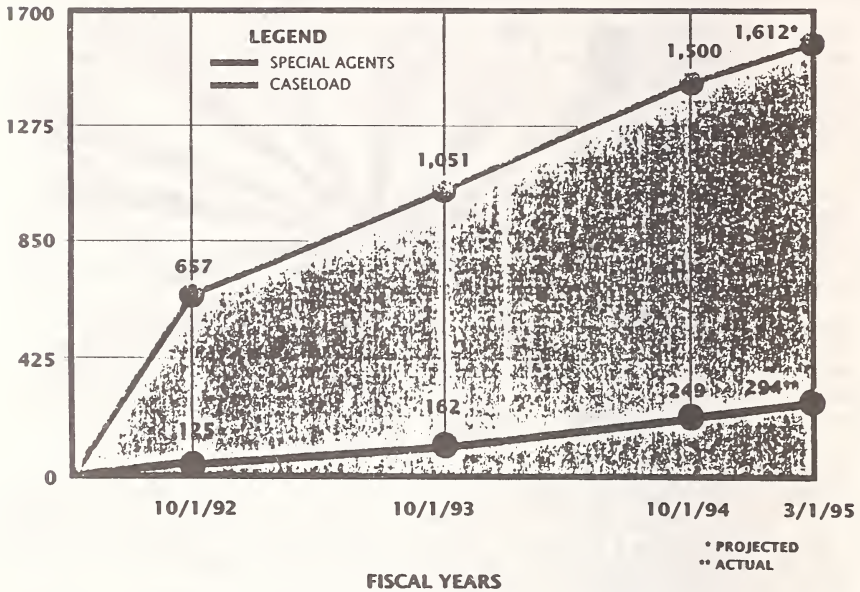
The list of schemes is as broad as the criminals' imaginations. The single thread that weaves through each investigation is corrupting the business side of medical care. Whether it is a government agency, private insurer, or private citizen—the system is built on payors who must trust those who submit claims for medical services, medications, treatments, and supplies.

Health care fraud is a top national priority of the FBI. Dedicated health care fraud squads have been established in seven of our largest field offices: Baltimore, Chicago, Detroit, Los Angeles, Miami, New York, and Philadelphia. We have formed additional health care fraud squads in Dallas, Houston, and New Haven. Most recently, two health care fraud squads have been developed in Washington, DC.

The FBI has dedicated more money, resources, time, and energy to its health care fraud initiative. More must be done. Health care fraud has not been investigated and prosecuted as efficiently and effectively as we would like due to resource issues and litigation over scope of Federal laws. Unfortunately, most FBI field offices report a large number of unaddressed cases. Several offices have characterized the health care fraud problem which they can address as only the "tip of the iceberg" in the overall health care crime problem for their territories.

As I state, the FBI presently has 249 agents assigned to health care cases, up from 97 in 1992 (see Chart 1). The FBI's health care caseload has increased to over 1,500 pending matters—a 142-percent increase in only 2½ years.

CHART 1.—NUMBER OF FBI SPECIAL AGENTS ASSIGNED TO HEALTH CARE FRAUD COMPARED TO CASELOADS



As I indicated previously, no segment of the health delivery system is immune from fraud. Ironically, all types of recipients, providers, and business people are committing fraud. Many of the schemes presently under investigation are highly complex and difficult to prove. These investigations require large investments of resources, time and effort.

Because of the demands of these investigations, the FBI had adopted a team concept in addressing this problem. A large percentage of our investigations are being conducted jointly with other agencies, particularly the HHS Office of Inspector General and the State Medicaid Fraud Control Units. Most of our field offices are engaged in one or more health care fraud task forces or working groups. The FBI also has regular and productive contacts with State and local agencies and the insurance industry, including groups such as the National Health Care Anti-Fraud Association of the National Insurance Crime Bureau. We have reached out to professional organizations such as the American Medical Association and the Federation of Chiropractic Licensing Boards. Each of these organizations brings essential skills and knowledge to our enforcement efforts. We are expanding our relationships with similar types of organizations.

The FBI has expanded its health care fraud training program to include agents, State and Federal prosecutors, investigators from private insurers and representatives from State and Federal regulatory agencies. Since 1992, the FBI has sponsored five training seminars for private health insurance executives. All of our training seminars have focused on identifying fraud trends in the medical system, coordination of investigations, developing innovative investigative techniques, sharing information, and day-to-day strengthening of working relationships.

This coordinated effort with private insurers and other agencies has resulted in many changes. These changes have made it harder for criminals to pursue their illegal activities.

In one of the FBI's biggest health care fraud cases, code named "Goldpill," the FBI attacked drug diversion on the streets of New York and in 17 other cities throughout the United States. Prior to exposure of the crime problem, Medicaid patients were allowed to bill Medicaid for unlimited supplies of prescription drugs. Medicaid patients would visit clinics and pharmacies on a daily basis and sell their prescriptions on the street for cash. New York's Medicaid system estimated over $400 million was being squandered annually through these schemes.

The clinic visits of medications were all billed to Medicaid. Since exposure of the problem, New York and other State Medicaid systems have adjusted their reimbursement procedures. They now limit the number of prescriptions Medicaid patients can receive on an annual basis.

In another example, the investigation of a national psychiatric hospital chain prompted many private insurers, as well as the government, to review reimbursement policies for psychiatric and chemically dependent patient hospital stays.

Statistically, FBI health care fraud convictions have risen dramatically each year since 1992 (see Charts 2 and 3). Financial recoveries have returned money to the Federal Government, States, and private insurers. Indeed, these accomplishments have more than paid for the costs associated with investigating many of these complex cases and enterprises. In health care investigations, the return has been $13.65 in fines, recoveries, restitutions, and forfeitures for every dollar spent.

CHART 2.—FBI MEDICAL FRAUD CONVICTIONS

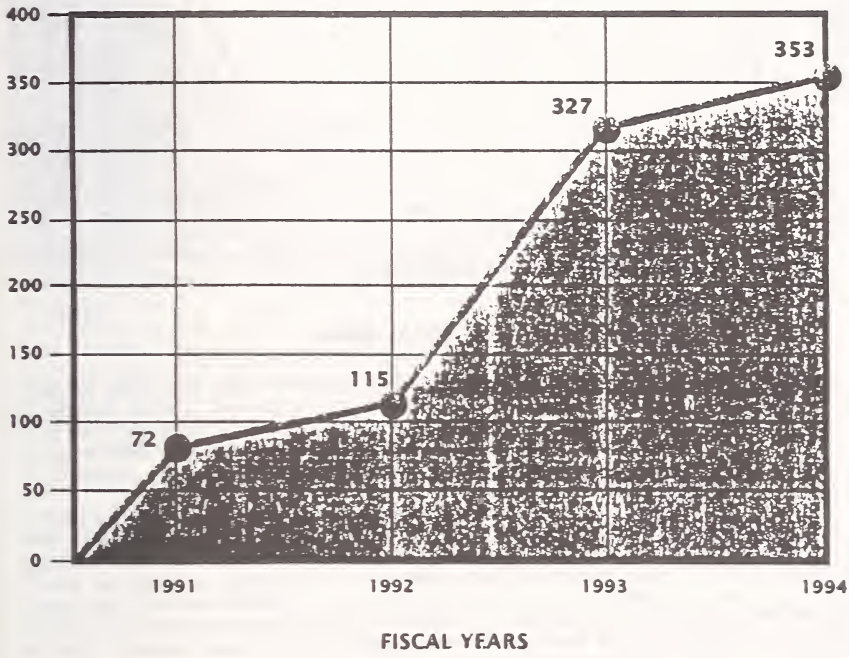
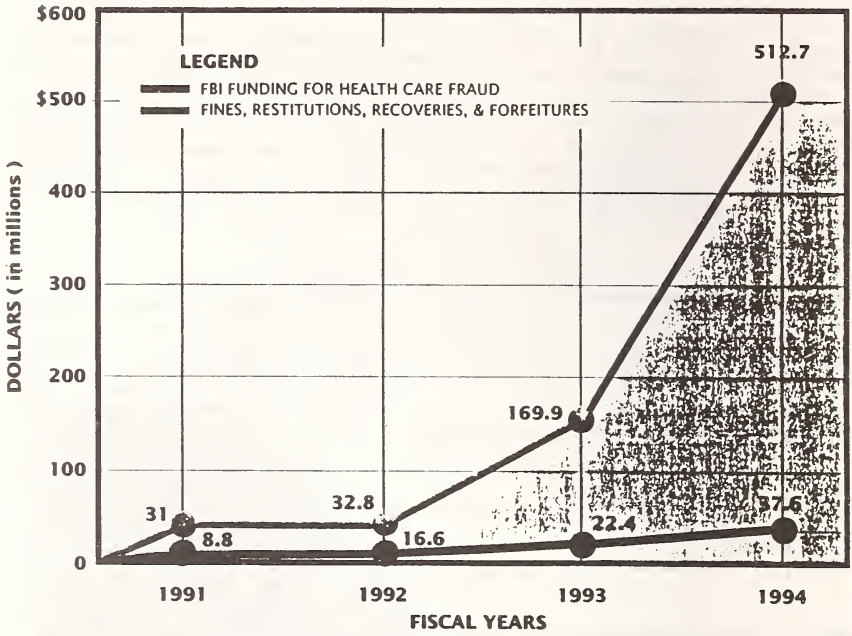


CHART 3.—FBI FUNDING FOR HEALTH CARE FRAUD COMPARED TO FINANCIAL RECOVERIES OBTAINED



According to the National Health Care Antifraud Association and other industry watchdogs, this Nation's health care system loses up to 5 percent of what Americans spend on health care, or $44 billion each year, to fraud. Many of these schemes have become very imaginative. They often are so creative they afford clever defense attorneys the opportunity to argue that they do not fall strictly within the elements for prosecution under current Federal laws.

There are many common health care frauds the FBI has uncovered: fraudulent billing schemes by durable medical equipment suppliers; nursing homes scams; hospital billing frauds; psychiatric hospital and diet clinic scams; laboratory frauds; pharmaceutical frauds; corrupt billing schemes by physicians; "rolling lab" scams which prey on the elderly and defraud Medicare and private insurers; workmen's compensation frauds; home health care schemes; and, many other frauds by corrupt businesses which provide ancillary services to the health care industry. Let me elaborate on some of the schemes we have detected.

KICKBACKS

Kickbacks occur in virtually every segment of the health care system. The inducements offered to providers take both unsophisticated and complex forms. In one recent case, a major hospital corporation sought the referral of patients from doctors in their communities. To induce those doctors to refer patients to their facilities, the medical center purchased the office buildings owned by the doctors at twice the building's value. Another medical company selling pacemakers provided free trips and prostitutes to doctors to induce them to use their product.

Some companies pay medical doctors and administrators in teaching hospitals huge sums of money for access to their patient bases. The funds provided to the doctors are disguised as individual research grants. In some cases, the research reports are prepared by company employees or students and submitted under the doctor's name. In some cases, cash is paid for the doctor's referrals.

The list of types of kickbacks is endless. Regrettably, the Federal antikickback law only applies when Medicare or Medicaid patients are being treated, and does not explicitly cover other government programs and private insurance plans. Current Federal law does not explicitly cover other government health care programs.

Broader kickback laws are needed with both civil and criminal remedies to cover all Federal health care programs and private insurers.

DURABLE MEDICAL EQUIPMENT [DME] FRAUDS

FBI investigations and the resulting intelligence developed have shown that DME fraud is a significant criminal problem. DME frauds are perpetrated through several schemes. DME companies often pay kickbacks to doctors, nursing homes, and hospitals for obtaining supply contracts. Medicare and private insurance companies are programs easily targeted by these unscrupulous businessmen. In New York, Russian-organized crime has engaged in a complex conspiracy through the submission of tens of millions of dollars in fraudulent DME claims. Subjects have been known to use aggressive telemarketing scams to fraudulently bill for unnecessary DME supplies and services. Other subjects obtain patient lists from nursing homes and routinely bill for products or services which are neither needed nor rendered.

PSYCHIATRIC HOSPITALS

In recent years, health care benefits have expanded to cover treatments for substance abuse, alcoholism, and mental depression. Publicly traded companies engage in corporate-driven schemes to maximize billings for patient beneficiaries. Generally, health insurance allows for coverage of in-patient treatment up to 28 days, thus enabling hospitals to collect up to $40,000 per patient. Unfortunately, greedy businessmen are preying on individuals with health problems, profiting at their expense. In addition, these businessmen and professionals are defrauding government programs and private insurers of billions of dollars annually from in-patient hospitalization. We have even identified cases where patients have been fraudulently diagnosed and forcibly admitted into psychiatric treatment programs when legitimate doctors determined they posed no threat to the community or themselves.

Often, patients are subjected to batteries of bloodtests, xrays, shock treatment, and other services. One such treatment involves the doctor providing the patient with wave therapy, which involves a simple wave of the doctor's hand during routine rounds. Thereafter, the doctor submits bills to the government program or insurance companies for $125 for individual therapy. There have been numerous allegations about this from private insurers involving millions of dollars of fraudulent billings.

DIET CLINICS

Diet clinics involved in criminal activity perpetuate fraud by soliciting patients—usually through mass media—and promise weight loss at nominal expense to the patient. Customers who frequent diet clinics are often required to undergo a cursory psychological examination, a series of blood tests, xrays and other ancillary tests. These services are then billed to insurers under the false pretense of a manufactured psychological malady.

These clinics solicit patients promising an in-house respite at a country club-type facility. Patients are provided airfare at no expense—and are often provided a chauffeured limousine to the hospital. Group therapy sessions, such as trips to shopping malls, amusement parks, and deep-sea fishing excursions, are billed as treatment for mental illness. The hospital stay, as well as all services provided, are billed to privately insured carriers based upon a purported psychiatric diagnosis when, in fact, the patients were at the clinic to lose weight.

The clinics accomplish the fraud by misrepresenting the medical conditions of their customers in order to justify payments for the tests and other services.

When conducting these investigations, it is difficult to differentiate concern for the patient's recovery and business profits. Many cases are solved by the cooperation of honest employees and the use of sophisticated investigative techniques. Some investigations have revealed that taxi, limousine, and shuttle bus services are often disguised in billings to insurance companies as ambulance services. To date, frauds of this nature have resulted in billions of dollars paid by private insurance companies.

Some diet clinics and psychiatric hospitals now contract with and pay for outreach counselors or brokers. They act as middlemen who, in turn, pay psychiatrists, psychologists, social workers, alcohol counselors, school counselors, and probation officers for sending patients to these facilities.

PHARMACEUTICAL DIVERSIONS AND PHARMACY BILLING FRAUD

The FBI's efforts in Operation Goldpill, in coordination with the Food and Drug Administration and the Drug Enforcement Administration, may best illustrate the breadth of criminal activity contaminating the health care industry.

Operation Goldpill involved the investigation of two types of medical fraud schemes. The first scheme involved the diversion of noncontrolled pharmaceutical medications—the kind of drugs all of us obtain legally with a doctor's prescription. Diverted, contaminated prescription drugs were sent throughout the United States and were being sold to the unsuspecting public.

In Operation Goldpill, the FBI used court-ordered telephone wiretaps to broaden its investigation. In written affidavits supporting the arrests, subjects were quoted speaking to pharmacists and other diverters about their activity.

Two diverters were overheard mocking criminal penalties saying "* * * most of the time you get 20 years to life you walk out on your own recognizance." Later in the same conversation, the diverters discussed the vast amounts of cash being generated by the fraud scheme and said they could not keep putting twenties in their "vault box" because it was taking up so much space. One diverter remarked, "you're going to have to have a mausoleum."

Other FBI investigations continue to demonstrate that pharmaceutical diversions remain a significant criminal problem throughout the United States.

The second pervasive criminal activity that the Goldpill cases focused on is the fraudulent submission of bills by pharmacies. This scheme deliberately defrauds federally funded Medicaid programs and private insurance carriers, driving up the costs of health care to all consumers and taxpayers.

DOCTORS

Physician frauds revolve around the submission of false claims to the government and private insurers, as well as the receipt of kickbacks. Investigations have revealed false billings by doctors occurring when:

The service was never rendered;

A service was in fact rendered, but a more expensive procedure which was not performed was billed;

The service was performed fewer times than it was billed;

The diagnosis code on the billing was altered to reflect more expensive treatment and procedures;

The service was not rendered by the qualified professional but was rendered by a lesser qualified or unqualified individual;

Chiropractors performing simple therapy on a patient and then billing for multiple procedures; or

Podiatrists billing for extensive medical procedures when they actually only clipped a patient's toenails.

LABORATORY SCAMS

One example of a typical lab scam investigated by the FBI involved medical laboratories which "sink test" blood and urine. In this "procedure," blood and urine specimens are dumped down the sink by lab personnel without performing any tests. The lab then reports the test results as being within normal range.

Today, investigation has shown some clinical laboratories engage in massive billing fraud schemes. For example, corporate officers have conspired to increase billings to the government and private insurers by adding tests to their automated blood chemistry panel known as SMAC [Sequential Multi-Analysis Computer]. Because it is highly informative and relatively cheap, the SMAC series is the single most popular blood lab test ordered by doctors.

As a part of these schemes, companies market the chemistry panel as part of a health survey profile that also includes tests not included in the standard SMAC. As a result, doctors wanting the standard SMAC are misled into ordering the entire profile. However, when the companies bill the tests to the government, insurers, or patients, the extra tests are billed separately at a much more expensive rate.

While this may not sound significant, this type of scam has a dramatic payoff. In one recent case, 2 years before a company added Ferritin—a test that measures iron in the blood—to the profile, Medicare paid less than $500,000 to the company for the Ferritin blood test; 2 years after the Ferritin test was added, the company received more than $31 million from Medicare in increased revenues.

Also, we have seen evidence of labs paying kickbacks to clinic owners or doctors for performing extensive blood work, urine tests, MRI's, or xrays. Patients them-

selves have accepted cash for providing their Medicare/Medicaid cards to the clinic or lab owners.

WORKERS COMPENSATION AND ACCIDENT CLAIMS

Private insurers and the government lose billions of dollars annually to phony automobile accident and "slip-and-fall" claims. Ongoing investigative matters and their resulting intelligence indicate that Federal and State governments, as well as private insurers, lose billions of dollars in medical and liability claims annually to medical doctors, lawyers, and parties faking injury. Normally, based strictly on the financial decision to avoid litigation costs, insurance companies agree to settle claims, at times through arbitration. The corrupt chiropractor, doctor, and attorney sometimes conspire in structuring the fraud so that the arbitrator is not able to determine that the claim is invalid.

HOSPITAL AND NURSING FRAUDS

Some nursing homes and hospitals often bill insurers or Federal Government programs. Frauds revolve around the submission of false claims. False billings by health care providers generally occur when:

Services are never rendered;

A service is rendered, but a more expensive procedure is billed;

The service is performed fewer times than it is billed;

The diagnosis code is altered to justify more expensive treatment and procedures; or

The service is not rendered by the qualified professional but is rendered by a lesser qualified or unqualified individual.

In two recent cases in separate parts of the country, hospital administrators have been convicted for embezzling funds from their facilities using elaborate money laundering schemes. Each of those cases has led to other significant fraud investigations involving doctors and businesses that do business or practice medicine at the hospitals.

False representations are also made in the preparation of Medicare cost reports. Cost reports are prepared by all hospitals, nursing homes, and home health care agencies which provide services, treat, or bill Medicare patients. These cost reports are prepared by each separate medical facility and submitted on an annual basis to a Medicare fiscal intermediary or Medicare carrier. Often, the cost reports contain improper and extravagant expenses attributed to these facilities which are passed on to Medicare.

HOME HEALTH CARE

Home health care is fast becoming an alternate prescription for in-patient hospital treatment. Unfortunately, no recipe for improving patient care can exist without potentially adding the fraud ingredient. Some home health care providers fraudulently bill for services not rendered, pay kickbacks to hospital staff and doctors for patient referrals, and bill for a service which was performed more times than it was provided.

In a recent case, agents discovered the presence of an organized criminal enterprise providing fraudulent home health care services. This conspiracy operated throughout many States. Further investigation determined that several businesses operated as brokers who sought out corrupt physicians and matched them with home infusion agencies which encouraged the use of their services. The home infusion providers were found to be paying kickbacks to the physicians for each patient prescribed in home treatment. The federally funded Medicare program as well as private insurers fell victim to these billing fraud schemes.

AMBULANCE SERVICES

Another area susceptible to fraud involves ambulance companies billing for emergency conveyance when no emergency existed, submitting invoices for trips involving nonexistent oxygen use, and charging for higher than average mileage per trip.

As an example, in a recent case in the Southeast, an individual operated an ambulance service that also provided nonemergency transportation for medical treatment for Medicaid recipients. Transportation should have been billed at the rate of $2.95/round trip. Instead, trips were being fraudulently billed as ambulance transport by stretcher at the rate of $55.00/round trip. As many as 175 trips a day were being billed at the higher rate, creating a fraudulent difference of $9,108.75 per day.

CONCERNS WITH EXISTING FEDERAL LAWS

With all of our successes, there are many cases which may go unaddressed or are difficult to prosecute due to defense attempts to exploit arguable gaps in the law.

In a recent case, a medical diagnostic company paid kickbacks to chiropractors for x rays and full body studies which included thermography tests, nerve conduction tests, and MRI's. The businessman billed private insurers between $1,500 and $4,000 for each patient tested. He paid kickbacks ranging from $100 and $350 per test to approximately 20 chiropractors. The investigation determined that the kickback incentives affected the medical judgments of the chiropractors. Regrettably, this kickback activity is not directly covered by Federal law, criminal or civil. This businessman took great care not to test Medicare patients, knowing that testing them in return for paying a kickback would violate the Federal antikickback law. Similar kickback scenarios are common throughout the country.

The health care system is being infiltrated by corrupt criminal enterprises. There are a number of health care fraud cases under investigation which represent criminal organizations. Laws must be toughened to afford law enforcement the ability to dismantle these organizations.

For instance, many of the staged automobile accident cases involve highly structured groups which operate organizations throughout the United States. We have identified dozens of these groups and they generate billions of dollars in fraudulent claims to insurers. FBI investigations are revealing similar trends in home health care, clinic operations, and nursing home enterprises.

TOOLS FOR INVESTIGATORS/PROSECUTORS

As I have stressed, health care fraud cases are often complex schemes which are difficult to investigate and prosecute. These schemes are a relatively new phenomenon that, at times, have put criminals ahead of the law. Investigators and prosecutors lack tools that would greatly enhance the effectiveness of the Federal Government's enforcement efforts. For example:

The current kickback statute covers only Medicare and Medicaid. It does not cover other government programs, private insurers, or other health care providers. The coverage of the Federal antikickback statute needs to be expanded. We will work with the committee to explore the most effective ways to accomplish this. There should be an explicit criminal and civil bar on such kickbacks.

Complex criminal organizations are involved in multimillion dollar health care schemes. There must be effective prosecutive tools to combat this type of crime.

Likewise, criminal organizations involved in health care fraud are often impenetrable by informants or other means. Criminal conversations, as you know, are vital evidence of intent. Thus, court authorized wiretaps are a necessary means to collect the evidence needed to prosecute health care fraud violations. Health care fraud, however, is not a predicate offense for court authorized wiretaps.

There is no specific health care fraud statute. As a result, prosecutors must rely upon complex legal theories in prosecuting health care fraud cases. A straightforward health care fraud statute would simplify the prosecution of these cases and greatly enhance the ability of law enforcement to attack this problem.

Other tools, such as a specific false statement provision, the ability to share grand jury information with civil attorneys and forfeiture provisions, likewise would be of great help.

CONCLUSION

Mr. Chairman, during the 1980's, the country endured a host of major crime problems including the war against illicit drug trafficking, the savings and loan crisis, defense procurement corruption, organized crime syndicates, and securities scandals. When confronted with those crises, Congress passed tougher financial institution laws, forfeiture laws, drug laws, and money laundering laws.

Health care fraud is a very serious crime problem in the 1990's. Fraudulent activity in the Nation's health care system—one-seventh of our economy—is on the rise. Today, we see cocaine dealers turning into health care fraud entrepreneurs. The Russian Mafia, as well as other organized crime groups, are engaged in creative schemes to siphon money from government and private health care trust funds.

The FBI will continue to place a high priority on this important work. We look forward to working with local, State, and Federal law enforcement, regulatory agencies, and the private sector in combating health care schemes.

I would be happy to respond to any questions from you or members of the committee.

Mr. KUBIC. For the record, if you would, I will submit my statement and provide just some general observations and comments. The FBI recognizes that there is a very serious need to coordinate our efforts with both the State law enforcement authorities in the Medicaid Fraud Control Units, as well as the other Federal investigators represented by the HHS IG.

And to achieve that goal we have taken a number of steps. For example, I recently authorized the exchange of one of my agent supervisors, who will serve at the HHS IG headquarters and, in return, one of the HHS IG investigators will serve at FBI Headquarters to facilitate coordination.

We have also initiated some discussions with a former assistant U.S. attorney who currently serves as one of the Medicaid Fraud Control Unit Directors in an effort to—I hate to use the term, steal—but to get her services perhaps on a full-time basis to work in headquarters.

The Department has also taken a lead in trying to facilitate this coordination. On a monthly basis, Jerry Stern—who you may or may not know, may or may not have testified before your committee in the past—has served to bring together the relevant agencies to discuss the problem, to review our investigative strategies, and then to try to formulate some solutions to this particular problem.

As I mentioned, currently we have about 249 agents throughout the United States working full-time fraud in the broad area of health care fraud. We also have about 600 agents who are assigned health care fraud cases in other parts of the United States, they are not working full-time.

We believe that one of the key ways to approach the problem is through a regular exchange of information, through candid discussions, and through joint investigative efforts.

In my formal remarks, I mention that within Georgia, one of the more recent Medicaid Fraud Control Units has been established. And that particular unit has about 19 GBI investigators. As was the intent of Congress in 1977, it brings together not only the investigators but it also brings together the prosecuting attorneys, it brings together auditors who, often times are the first to see the fraud scheme, and it brings together some analysts.

The FBI, in the Atlanta Division, will work with that unit, as we have with the other units throughout the United States.

Thank you very much.

[The prepared statement of Thomas T. Kubic follows:]

PREPARED STATEMENT OF THOMAS T. KUBIC, CHIEF, FINANCIAL CRIMES SECTION, FEDERAL BUREAU OF INVESTIGATION

Good afternoon, Mr. Chairman and members of the committee.

It is my pleasure to be here today representing the Federal Bureau of Investigation as your committee examines the issue of Medicaid fraud.

As Director Freeh testified just a few weeks ago before Senator Cohen's special committee on aging, the health care fraud problem has reached epidemic proportions. Fraud is rampant in the $884 billion U.S. health care industry. Conservative estimates put the annual losses associated with health care fraud at $44 billion. So that the committee has the FBI's full views on this problem, I would ask that both the short and long statements of the Director, as well as accompanying charts, be submitted for the record.

In 1993, the Federal Government paid 31 percent of the Nation's health care bill. That same year, Medicaid and Medicare programs spent $272 billion for health care. The Federal share of Medicaid spending was $76 billion while the State and local

share of Medicaid spending was $41 billion. In 1993, there were 33 million people who received some type of Medicaid benefit.

The FBI currently has 249 special agents assigned full time to investigate 1,612 health care fraud matters. Our experience in these cases has been that those individuals or groups that choose to defraud our health care system do not discriminate. Generally, those who commit fraud against the Medicare program are also defrauding the Medicaid program and likewise are cheating the private insurance companies. We rely heavily on the partnership with the State Medicaid Fraud Control Unit or MFCU's to investigate fraud schemes involving the Medicaid program.

The MFCU's are federally funded State law enforcement entities which investigate and prosecute provider fraud and misconduct in the Medicaid program. In 1977, Congress passed the Medicare-Medicaid antifraud and abuse amendment which sought to remedy Medicaid fraud and patient abuse in nursing homes. The MFCU's have enjoyed tremendous success and as indicated are vital team members in the government's effort to curb fraud in the $1,217 billion Medicaid program. Medicaid continues to finance half of the total costs of nursing homes, spending 45 percent of the $53 billion that was spent on institutional care in 1990. The MFCU's, in addition to investigating fraud in the nursing home industry, also have responsibility to investigate allegations involving patient abuse. The combined investigative staff of the MFCU's is approximately 1,150, partially funded by Federal moneys totaling approximately $69 million. This is a relatively small amount when one considers that the California Medi-Cal budget alone is $16 billion. The Office of Inspector General in 1979 was given the responsibility for overseeing the MFCU program. The Office of Inspector General in this capacity certifies and recertifies the MFCU offices to insure that they are complying with Federal regulations and monitors their statistical accomplishments.

The MFCU's regularly conduct joint investigations with other agencies to include the FBI, Office of Inspector General, Postal Service, Defense Criminal Investigative Service, local U.S. attorney's offices and attorneys from the Department of Justice here in Washington, DC. The FBI recognizes that this team approach is vital to success in combating the rising problem of health care fraud.

In furtherance of this team concept, we meet regularly with the leaders of the National Association of Medicaid Fraud Control Units. We have implemented a 6-month exchange program wherein an FBI supervisory special agent will be detailed to the IG's office and an HHS inspector will be assigned to the health care fraud unit at FBI headquarters. Likewise, to further enhance our work with the MFCU's, we are seeking authority to hire a former assistant U.S. attorney and current MFCU Director. These efforts are designed to improve coordination between the FBI and HHS–OIG and the State MFCU's.

The FBI recognizes that very few successful cases are the result of the work of one sole investigative agency. Because of this, almost all of the FBI's 56 field offices participate in joint health care fraud task forces, many of which include representatives from MFCU's. Just over 1 year ago, the FBI and the National Association of Attorneys General jointly sponsored a 3-day conference that paired FBI supervisory special agents with the Directors of the MFCU that served the same geographic region. Topics of mutual interest were discussed and efforts were made to facilitate future joint investigations. Additional similar conferences are planned for the future.

Currently there are 45 federally funded and certified State MFCU's, with Kansas and Montana currently undergoing a certification process. The Governors of North Dakota and Nebraska have received waivers from the Secretary of Health and Human Services and do not have MFCU's. The State of Idaho has no MFCU and has no pending request for waiver.

The 45th and most recently certified State is Georgia. The approach of the State of Georgia to the investigation of health care fraud is an approach that the FBI encourages as an effective way to pursue health care fraud investigations. The State legislature recently authorized the State attorney general's office and the Georgia Bureau of Investigation [GBI] to oversee the creation of a State health care fraud unit. This entity will be staffed by 19 investigators from the GBI, 4 auditors from the Georgia Department of Audits, 5 prosecutors from the State attorney general's office and two analysts from the GBI. The integrated structure of investigators and prosecutors illustrates that the State of Georgia endorses the team approach to health care fraud investigations as envisioned by the Congress in 1977. This structure ensures that the investigations are coordinated from the predication of a case through the indictment and trial phase. Federal resources, to include FBI agents from our office in Atlanta and the U.S. attorney's office in the northern district of Georgia, will work closely with this new State fraud unit.

The following are case examples where the MFCU has played a significant role in Medicaid investigations:

In the area of nonemergency medical transportation, some ambulance companies are billing for emergency conveyance when no emergency exists, submitting invoices for trips involving nonexistent oxygen use and charging for higher than average mileage per trip.

In a recent FBI–MFCU investigation in the Southeast, an individual operated an ambulance service that also provided nonemergency transportation for medical treatment for Medicaid recipients. Transportation should have been billed at the rate of $2.95 per round trip. Instead, trips were being fraudulently billed as ambulance transport by stretcher at the rate of $55.00 per round trip. As many as 175 trips a day were being billed at the higher fraudulent rate creating a difference of over $9,000 per day.

Last year, Palm Beach County, FL, taxi drivers were paid $15 million by Medicaid in reimbursement for alleged transportation of Medicaid patients. That amount equaled what all other cab companies in the State of Florida received for this same service; even though Palm Beach County is home to only 5 percent of Florida's Medicaid recipients.

The FBI's 1992 national initiative against pharmaceutical diversion, Operation Goldpill, targeted two types of Medicaid fraud. The first scheme involved the diversion of noncontrolled pharmaceutical medications—the kind of drugs all of us obtain legally with a doctor's prescription. These diverted and contaminated prescription drugs were obtained by fraudulently billing Medicaid and then illegally sold to the unsuspecting public. In Operation Goldpill, the FBI used court-ordered telephone wiretaps to expose this type of Medicaid fraud.

The second pervasive criminal activity that the Goldpill cases focused on involved the fraudulent submission of bills by pharmacies to Medicaid. In one case in Los Angeles, pharmacists were dispensing generic brands of noncontrolled medications while billing private insurance companies for name brands. These pharmacists billed insurance companies for double the cost of a generic drug; thus reaping thousands of dollars of illegal profits. In this same case, the same pharmacists would bill for refill prescriptions that were never requested by the patient. This scheme deliberately defrauded Medicaid and private insurance carriers, driving up the costs of health care to all consumers and taxpayers. Many State MFCU's participated in Operation Goldpill and the intelligence pertaining to diverter identities and schemes furnished by them was invaluable to the success of this operation.

Today, investigations continue to show clinical laboratories engaged in yet other types of Medicaid billing fraud schemes. For example, corporate officers have conspired to increase billings to the government and private insurers by adding tests to their automated blood chemistry panel called the sequential multianalysis computer or SMAC. The SMAC series is the single most popular blood lab test ordered by doctors because it is highly informative and relatively cheap.

As a part of these schemes, companies market the chemistry panel as a health survey profile that also includes tests not included in the standard SMAC. Doctors wanting the standard SMAC are misled into ordering the entire profile. However, when the companies bill the tests to the government insurers or patients, the extra tests are billed separately at a much more expensive rate.

While this may not sound significant, this type of scam has a dramatic payoff. In one recent case, 2 years before a company added a test that measures iron in the blood to the profile, Medicare paid less than $500,000 to the company for the Ferritin blood test. Then 2 years after the Ferritin test was added, the company received more than $31 million from Medicare in increased revenues. Corporate settlements in this case reached $100 million to the Federal Government and $10.4 million to 33 State MFCU's.

We continue to see evidence of labs paying kickbacks to clinic owners or doctors for performing extensive blood work, urine tests, MRI's or x rays. Patients themselves have accepted cash for providing their Medicare/Medicaid cards to the clinic or lab owners.

The FBI has broad jurisdiction to address all areas of health care fraud; including both federally and privately funded insurance programs. A coordinated effort is needed to combat this problem on all fronts. With Federal dollars financing the Medicare program and much of the Medicaid program, the Bureau has a mandated responsibility to investigate allegations of fraud. In the area of privately insured programs, the violation of many Federal statutes to include both mail and wire fraud, requires the FBI's attention. No one agency can successfully confront this massive crime problem alone. These investigations require large investments of resources, time, and effort.

The Department of Justice has made the prosecution of health care fraud one of its top priorities. I can assure the committee that the FBI, with the cooperation and assistance of the State MFCU's, the HHS–OIG and other investigative agencies, will continue to aggressively pursue those committing fraud on our health care system.

Mr. Chairman, I want to thank you for this opportunity to testify today. I would welcome any questions you may have.

STATEMENT OF DANIEL R. ANDERSON, VICE PRESIDENT, NATIONAL ASSOCIATION OF MEDICAID FRAUD CONTROL UNITS

Mr. ANDERSON. Thank you, Mr. Chairman and members of the committee. I have been sitting here all morning listening to your witnesses. It struck me, listening to a number of the witnesses, how, I think, our experiences in the States, particularly in the Medicaid Fraud Control Units, can be somewhat instructive to any discussion of block granting.

I think in many ways, the Medicaid Fraud Control Unit was, the program for the Medicaid Fraud Control Units was an example of a very early stage of block granting. Let me explain what I mean.

As you know, back in the 1960's, Congress established the Medicaid program. At that time, they did not consider the need to establish an antifraud component in that program. It was, I think, widely believed that if you gave these Federal dollars to the States, since the States were matching those Federal dollars in the Medicaid program, any thefts from the Medicaid program would be prosecuted by local prosecutors.

What they did not take into account is how complex these cases are. As a prosecutor who has been doing this for 10 years, I can tell you that it is not enough to just know criminal law. You have to know the health care field and you have to know the Medicaid regulations and you have to know the various nuances of each profession within the health care field.

And, for a typical local prosecutor, that means several months, perhaps several years, of a learning curve before he or she can prosecute these types of cases. The result is that they were ignored. And it was only after some scandals broke, in fact in the State of New York, and the press got ahold of it, and several Congressmen started their own inquiries, that it was determined that Medicaid dollars were not being used in many cases to render health care, but rather were being used to buy yachts and other luxury items for Medicaid providers in the country.

So in 1977 Congress held special hearings and passed special legislation that established the Medicaid Fraud Control Unit program.

As my colleagues here pointed out, we are partially federally funded. We receive matching grants from the State and from the Federal Government to police the Medicaid program.

Our success record has been pretty immense. We have over 7,000 convictions. We have recovered hundreds of millions of dollars in recoveries on behalf of the Medicaid program.

We have seen any number of schemes—and I would like to just take a moment and tell you what the typical schemes are that we are seeing in the health care professions.

My colleague from HHS has already referred to the National Medical Enterprises case. That is exceptional only in the amount of money that was involved. We often see billing for fake services.

For example, I have now under investigation a doctor who, when we asked for his records, gave us a lot of EKG forms, which showed that he had done EKG's for each of this patients.

We were concerned about the numbers of EKG's he was performing. When we put them on transparencies and held them up to the light, they were all identical. He had done one EKG and photocopied it over and over and over again, and then billed Medicaid as if he had done it each time.

We are concerned about substituting generic drugs for name-brand drugs. Now, at first, that sounds like penny-ante, you know, you are talking a difference of maybe a dollar a pill in some cases.

But when you have a typical patient going in and getting 90 pills a month, that pharmacist has found a way to increase his profits by maybe $90 a month, maybe several hundred dollars a month depending on the type of pill that is being dispensed.

We have double billing issues in which health care providers would not only bill Medicaid for the service rendered, but will bill the patients themselves, or will bill another insurance company that may be covering that patient. So people are being billed twice.

We have unnecessary services being billed. And, frankly, as a prosecutor, that is an area that we tend to shy away from because we do not like to substitute our judgment for that of a health care professional. On the other hand, we have laboratories that we have prosecuted who have duped doctors into ordering very expensive blood tests, sometimes at a cost of $30, $40, or $50 per test.

The doctors do not need it, the patient does not need it, Medicaid or Medicare pays for it. You probably are familiar with a National Health Lab's case. They did this over the course of about 18 months and they were able to get $110 million from the Federal and State governments before they were caught.

We have people we have prosecuted for filling out false cost reports. For example, nursing home owners who may include their yacht or their Mercedes in a cost report for Medicaid reimbursement, somehow alleging that these services or these goods are being used for patient care.

We prosecute kickback cases. We have one, for example, a vendor in New York who was giving a TV or a VCR to a supply purchaser in a hospital for every time he ordered drain cleaner. So this person was taking home VCR's and televisions, and before he was done, in the course of a couple of months, he had had enough drain cleaner for that hospital to last the hospital until the year 2050. All, I might add, at a cost to Medicaid.

We are now getting involved in the home health care industry which, as you all know, is burgeoning. This year we expect to spend over $4 billion on home health care. And this is an area that is somewhat unregulated in the sense that it is occurring in someone's home. It is not like a facility where there are several checks built into the system.

Home health care providers may, for example, instead of sending licensed nurses out to take care of the patient, may be sending unlicensed individuals out. They may, as we found in several States, be billing us for services rendered to patients who died a year earlier, because the systems are not being checked properly. And they often fail to provide the very basic care that Medicaid is paying for.

You may be as surprised as I was to learn that Medicaid actually pays for medical transportation to and from a doctor's office. In a city, like mine, in Baltimore where we have a fairly decent mass transit system and a fairly decent subway, we are still paying for people to take taxis to and from their doctor's office. That is, we paid for it until it collapsed under the fraud.

It increased tenfold in the course of 3 years, because basically we put taxi cab drivers on the honor system and we told them they could bill us by the mile. Well, you can imagine what that meant? It meant phantom riders, people who had never got a ride to and from their doctor's office, people who would sell their Medicaid number to the cab driver in exchange for cash, so that he could use that Medicaid number to bill Medicaid.

We even had one guy, who for the sake of having the patient sign a voucher indicating that she had been taken to the doctor, would instead drive her to Burger King and get her burgers every day with her kids. So Medicaid was paying for her to go to a fast food place.

We have prosecuted any number of drug diversions. My friends from the FBI have talked to you in the past about Operation Gold Pill. Very simply, these are cases where doctors and other health care providers abuse their prescribing privileges and for the sake of cash, and in some cases, sexual favors, will trade prescription drugs for cash or sexual favors. All at a cost to Medicaid because not only do we pay for these prescription drugs, we often pay for the office visit that the doctor will charge us.

I might add, in regards to the prescription drug issue, that the trickle-down costs from these are fairly immense. Not only are we paying for the prescription drugs, not only are we paying for the office visits associated with those prescription drugs, but we pay all the attendant costs of drug addiction—Columbia University last year estimated 20 percent of all of our hospital admissions are the result of substance abuse.

So if you factor that out, that is a huge cost to Medicaid arising just for prescription drug abuse.

We are now looking at the future which is fraud in managed cases. Basically, we are talking about HMO's and what we are concerned about here is a number of things, primarily what we call underutilization, where the financial incentive on the part of health care providers is to render less care to healthy patients.

The incentive is to get more patients through your door on a daily basis because you are paid on a per-head basis. One doctor in Baltimore who we prosecuted was practicing alone and he was trying to see 90 to 100 patients a day, to the point where he had a rubber stamp made so that whoever came through the door had the same diagnosis. It read "lumbar spine arthropathy," and everyone's chart had the same stamp in it. Everyone's chart had the exact same blood pressure because he was not taking blood pressures, he was just writing them down.

We find these doctors are hiring unqualified help and passing them off as physicians so that their patients think they are seeing a doctor and, in fact, they are not even seeing a physician's assistant. They are seeing someone with no training whatsoever. And, of course, Medicaid is paying for a doctor's visit.

And, finally, in the area of managed care, we are very concerned about the marketing schemes that we are seeing with HMO's and the like. Right now, we have under investigation a situation in my State—and we have seen it in Arizona, where their whole Medicaid population is in an HMO—where kickbacks are being paid to State officials to get Medicaid information, so that they can then bill that information directly to Medicaid, as if they had been enrolled in an HMO.

And, on a nonfraud aspect, but certainly under the area of abuse in HMO's, we have actually seen HMO's disenrolling unhealthy patients. The Medicaid population, as you can imagine, often is quite sick because it is the poorest among us. And, yet, if you have AIDS, if you have a history of cancer, if you have all of these diseases that they do not want to deal with, they will disenroll you or provide some kind of disincentive for you to disenroll yourself.

So we have been very concerned about that. I talked about fraud. I know my time is very limited. I want to also stress that an important function of our units is to prosecute patient abuse and neglect. That is about 40 percent of our cases. We are the only units, nationwide, in each of our States that has this as our special mission, to protect the elderly and the vulnerable who are confined in Medicaid funded facilities. And we think that is a very important function that we perform.

I will conclude by, again, bringing you back to the point of block granting, because we are concerned that in the event that block grants occurs somehow the antifraud function will be overlooked. And we think it is vital that if Federal dollars come into any particular State that the string that be attached to those Federal dollars is a unit much like the Medicaid Fraud Control Unit that police that those funds are spent for health care.

In my written testimony, I have given you some very defined points, and some things that we would like to see included. But I would leave it, I would conclude, by saying that we think an antifraud function is vital to any block grant issues that we discussed here today.

And I, too, would welcome any questions that any of you might have.

[The prepared statement of Daniel Anderson follows:]

PREPARED STATEMENT OF DANIEL R. ANDERSON, VICE PRESIDENT, NATIONAL ASSOCIATION OF MEDICAID FRAUD CONTROL UNITS

Mr. Chairman, members of the committee, I am Daniel Anderson, Director of the Maryland Medicaid Fraud Control Unit. I am very pleased to appear before you today as the vice president of the National Association of Medicaid Fraud Control Units to discuss the role of the States in investigating and prosecuting health care fraud. The skyrocketing costs associated with health care delivery and the continued graying of our population have resulted in an increased reliance upon government-sponsored programs such as Medicare and Medicaid to provide much needed health insurance to those who would otherwise go without medical care.

The Medicaid program, which was established to provide health care to indigent patients, has seen its enrollment explode. Nationwide, the Health Care Financing Administration expected to spend more than $170 billion in fiscal year 1996 to sustain the Medicaid program; 30 years ago, when the program started, Medicaid expenditures were $1.5 billion. State expenditures for Medicaid have doubled in the past 5 years and in some urban areas, such as Los Angeles, Baltimore, and New York, it is not uncommon for one-fourth of the population to rely on the Medicaid program for their basic health needs. Even though Medicaid is generally funded 50 percent by Federal money, several States now spend between 15 to 20 percent of

their general budget to sustain the program. Medicaid also continues to finance almost half of the total costs for nursing homes, spending 45 percent of the $53 billion that was spent on institutionalized care in 1990.

This Nation is expected to spend $1 trillion on health care or 15 percent of our gross national product this year. Given these figures, it is not surprising that our health care delivery system has proven ripe for fraudulent activity.

The General Accounting Office [GAO] recently estimated that fraud and abuse accounts for 10 percent of health care costs, currently exceeding $800 billion, and while there may not be a way to establish a precise figure, we are certainly talking about many hundreds of millions of dollars of fraud and abuse in the Medicaid program alone. GAO stated further in testimony before the House Subcommittee on Crime and Criminal Justice on February 4, 1993, that only a fraction of health care fraud and abuse is identified and prosecuted. GAO acknowledged that without adequate resources effective investigation and prosecution of health care fraud is not possible.

During the past decade, in particular, we have literally seen a feeding frenzy on the Medicaid program, a period of unprecedented white-collar wilding in which wave after wave of multimillion-dollar frauds have swept through nursing homes and hospitals, to clinics and pharmacies, durable medical equipment [DME], radiology, and labs, and more recently, home health care. Although we do the best we can to put an end to program vulnerabilities, we still have profiteers who search and succeed in finding the next great loophole in the Medicaid system.

STATE MEDICAID FRAUD CONTROL UNITS

While the investigation and prosecution of health care fraud has only recently become a top national law enforcement priority, the States have been combating health care fraud for the past 17 years and are viewed as leaders in the detection and prosecution of fraud in the health care industry. Medicaid, established by Congress in 1965 is of course, the primary government health care program for approximately 34 million of America's poorest and oldest citizens. For the first decade after Medicaid was created, the system operated with few controls against fraud. Inadequate safeguards combined with multibillion-dollar expenditure levels made a substantial amount of fraud inevitable. The result was an unprecedented theft of government dollars as local prosecutors struggled with the difficult task of prosecuting these highly sophisticated crimes. Congress came to recognize an urgent need to address this loss after much media attention and congressional hearings highlighted the theft of taxpayer dollars and the harm suffered by Medicaid patients who were deprived of basic medical care. The result was legislation to establish specialized State-based strike forces to police the Medicaid program.

In 1977, Congress enacted legislation, the Medicare-Medicaid Anti-Fraud and Abuse Amendments (Public Law 95–142), which established the State Medicaid Fraud Control Unit Program. The objective of this legislation was to strengthen the capability to detect, prosecute, and punish health care fraud. In addition to investigating and prosecuting providers who defraud the Medicaid program, the mandate to Medicaid Fraud Control Units [MFCU's] specifically includes the authority to prosecute the abuse or neglect of patients in all residential health care facilities which are Medicaid providers. The units are staffed by professional teams of attorneys, investigators, and auditors specifically trained in the complex litigation aspects of health care fraud. The enabling Federal legislation emphasizes the necessity of having an integrated multidisciplinary team in one office in order to successfully prosecute these complex financial crimes. The units are required to be separate and distinct from the State Medicaid programs and are usually located in the State attorney general's office, although some units are located in other State agencies with law enforcement responsibilities such as the State police or the State bureau of investigation. The recently enacted Omnibus Reconciliation Act requires all States to have a Medicaid Fraud Control Unit by this year, unless a State can demonstrate to the Secretary of the Department of Health and Human Services [HHS], that it has a minimum amount of Medicaid fraud and that residents of health care facilities that receive Medicaid funding will be protected from abuse and/or neglect.

Since the inception of this pioneering program, 42 federally certified State units have successfully prosecuted over 7,000 corrupt medical providers and vendors and elder abusers—convictions that would not have occurred without this vital piece of legislation. These 42 units police 92 percent of the Nation's Medicaid expenditures with combined staff of approximately 1,150 and a total Federal budget of $69 million. This amount represents a small fraction of the total Medicaid budget that the units are responsible for policing. Last fall, South Carolina became the 43d federally certified MFCU. Georgia and Wyoming were certified in January of this year and

became the 44th and 45th MFCU's. Unit size varies State-by-State and is dictated to some extent by the size of State's Medicaid program. In Maryland, for example, our Medicaid budget is $1.8 billion and the unit employs 21 staff. New York is the largest unit with approximately 304 staff and Oregon is the smallest with 4.

In addition to the criminal consequences of MFCU cases—repayment of restitution, overpayments, State exclusions, incarceration, and often the loss of certifications, the ability to conduct business and professional licenses—the criminal convictions of the units become the basis for further Federal actions. The Federal actions that are reported to you by the Office of Inspector General [OIG] of the Department of Health and Human Services [HHS] include the underlying State convictions, judgments, forfeitures, civil settlements, Federal program exclusions, and civil monetary penalties. In fact, the majority of health care fraud convictions, penalties, and exclusions reported to you are based upon MFCU convictions. The MFCU's are the most efficient and effective law enforcement agencies in the battle against health care fraud and patient abuse.

PATIENT ABUSE AND NEGLECT

While this remarkable success in detecting and prosecuting Medicaid provider fraud is widely recognized, it is perhaps less well known that the units are the only law enforcement agencies in the country specifically charged with investigating patient abuse and neglect.

I would like briefly to share with you some of our findings in the area of patient abuse. Patient abuse can be classified into several categories. For example, providing inadequate medical or custodial care or creating other health care risks may constitute patient neglect. Physical abuse includes acts of violence such as slapping, kicking, hitting, or punching a patient and sexual abuse. Financial abuse includes the misappropriation of patients' personal funds such as commingling patient and facility funds or using patient funds to pay for facility operations.

Scores of investigations and years of cumulative experience have made it clear that the abuse, neglect, mistreatment, and economic exploitation of nursing home residents is a problem of far greater magnitude than previously thought. Our national association, in collaboration with the National Association of Attorneys General [NAAG], has therefore promulgated a model patient abuse statute—already adopted in several States—that would not only provide the necessary prosecutorial tools and enhanced penal sanctions for combating this type of shocking misconduct, but would also serve as a powerful deterrent to potential patient abusers.

Let me highlight a few examples of the units' work in this area:

A New York physician was criminally prosecuted for willful neglect and reckless endangerment of a nursing home patient in his care. He mistook a peritoneal dialysis catheter in the patient's abdomen for a feeding tube, and ordered that she be fed through the catheter. When this error was discovered 2 days later, he made a conscious decision to do nothing to help the patient despite expert advice that the patient required hospitalization for treatment. Finally, 10 hours later, the physician agreed to transfer the patient to the nearby hospital for care.

In Arizona, a residential care home owner was sentenced to serve 21 years—the longest sentence for elder abuse in the State's history—for neglecting and abusing his aged patients. To induce families to place their relatives in his facility, the defendant had lied to them about his licensure status.

Four nursing home officials in Philadelphia were charged with involuntary manslaughter in the death of two nursing home residents who died from massive and infected bed sores.

Beverly Enterprises, Inc., the largest nursing home chain in the Nation, agreed to pay Oregon $600,000 to improve care at their 17 facilities in the State, after an MFCU investigation of a Beverly home found evidence of inadequate staff training and supervision, and other conditions constituting an immediate threat to resident health and safety.

The third largest nursing home corporation in Texas—the ninth largest in the Nation—four corporate officers and four employees were indicted on charges related to the deaths of two facility residents. One patient allegedly died from neglect, and the other, who suffered from senile dementia, was allowed to wander from the nursing home, became lost, and died of exposure.

And beyond these egregious cases of corporate and management neglect, the units have also uncovered hundreds of incidents of individual nurses, aides, and orderlies, raping, sodomizing, beating, kicking, and force-feeding the helpless, often incompetent patients in their charge.

Congress enacted Public Law 95–142, not only because of the widespread evidence of fraud in the Medicaid program, but also because of the horrendous tales of nurs-

ing home patient abuse and resident victimization—and the units are justly proud of their record in protecting the frail and vulnerable institutionalized elderly.

PROVIDER FRAUD SCHEMES

In the past decade, we have seen a rapid increase both in the number of fraudulent schemes and the degree of sophistication with which they are committed. Although the typical fraud schemes such as billing for services never rendered, double billing, misrepresenting the nature of services provided, providing unnecessary services, false cost reports and kickbacks still regularly occur, new and often innovative methods of thievery have consistently occurred and are even just beginning to appear.

Medicaid fraud cases run the gamut from a solo practitioner who submits claims for services never rendered to large institutions which exaggerate the level of care provided to their patients and then alters patient records in order to conceal that lack of care. MFCU's have prosecuted psychiatrists who have demanded sexual favors from their patients in exchange for prescription drugs, nursing home owners who steal money from residents, and even funeral directors who bill the estates of Medicaid patients for funerals they did not perform.

The following are typical schemes corrupt providers may use to defraud the Medicaid program.

1. Billing for services not rendered

A provider bills for services not rendered, x rays not taken, a nursing home or hospital continues to bill for services for a patient who is no longer at the facility either due to death or transfer, and psychiatrists bill for SSI qualifying exams which do not occur.

2. Double-billing

A provider bills both the Medicaid program and a private insurance company—or the recipient—for treatment, or two providers request payment on the same recipient for the same procedure on the same date.

3. Substitution of generic drugs

A pharmacy bills the Medicaid program for a brand name prescription drug, when a low-cost generic substitute was supplied to the recipient at a substantially lower cost to the pharmacy.

4. Unnecessary services

A physician performs numerous tests which are medically unnecessary and result in great expense to the insurer.

5. Upcoding

A physician bills for more expensive procedures than were performed, such as a comprehensive procedure when only a limited one was administered, a psychiatrist bills for individual therapy when group therapy was given.

6. Kickbacks

A nursing home owner requires another provider, such as a laboratory, ambulance company, or pharmacy, to pay the owner a certain portion of the money the second provider receives from rendering services to patients in a nursing home.

7. False cost reports

A nursing home owner or operator includes inappropriate expenses for Medicaid reimbursement.

NEW SCHEMES AND TRENDS

Over the past few years, these so-called typical schemes have given way to more innovative ones. Recently, the units have identified serious fraud problems in several industries including laboratories, home health care, medical transportation, medical supplies, pharmacies, and imaging centers. The incidence of illegal drug diversion has risen sharply over the years, carrying with it a dramatic financial impact on the Medicaid program.

More and more States are enrolling their Medicaid population into managed care plans. While proponents of the managed care system believe that it is the best method for providing low-cost high-quality health care to more people, the experience of the fraud units reveal that no health care plan is immune from fraud and indeed fraud does occur in managed care plans.

Recent global settlements of cases involving multiple State and Federal entities have encouraged cooperative Federal/State efforts to protect the Medicare/Medicaid programs from health care providers or vendors whose activities know no borders.

BUSINESS MANAGEMENT COMPANIES

A significant trend is the merger, acquisition, consolidation, affiliation, and joint venture of health care corporations as a cost-saving business practice. The result is that the business judgments are overriding medical practices—witness the laboratory cases, such as NHL and the National Medical Enterprises, Inc. [NME] cases. In addition, we are beginning to see this in the form of self-referrals. Couple this with greed, unregulated businesses, and big government dollars, and it equals disaster.

LABORATORIES

Aggressive marketing techniques, not traditionally associated with the health care industry, have increased costs by adding marginally necessary or totally unnecessary tests to health care bills. One such example is the recent National Health Laboratories, Inc. [NHL] case where physicians were misled into ordering a rare, but expensive, diagnostic test when they needed only an inexpensive and basic blood chemistry. Investigators found that NHL induced doctors to order laboratory tests which were medically unnecessary by assuring that the additional tests would be free or of minimal cost. In fact, NHL was billing government insurers for these tests without the referring physician's knowledge. As a result of this scheme, the president and chief operating officer of NHL was sentenced to jail; and the corporation, after pleading guilty, settled with the Federal Government for $100 million and 33 State MFCU's for $10.4 million.

Billing for useless laboratory tests and cheating both government and private insurers is still occurring. In Maryland, a laboratory and its owner were found guilty of numerous counts of fraud and theft. The defendants were charged with billing government and private insurers for performing more than 8,000 unauthorized and useless diagnostic tests totaling nearly $150,000. The owner was also convicted of representing a laboratory which was in violation of the State's quality assurance laws. He was sentenced to serve 5 years in and ordered to pay $161,000 to Medicaid, Medicare, and several commercial health insurance companies.

The Illinois MFCU has charged several defendants with allegedly establishing a phony lab and billing Medicaid and private insurance companies for lab tests that allegedly were never performed by the lab. During a search of one of the defendants' home, tubes of what appeared to be human blood were found in the garbage can. Before the scheme was exposed, over $300,000 in payments from Medicaid and insurance companies passed through the corporate bank account.

Laboratories that provide drug testing for substance abuse programs have also been the subject of MFCU investigations. The Massachusetts MFCU indicted a drug testing laboratory and its president for allegedly overcharging Medicaid for tests it performed and then used in a series of fraudulent billing schemes to increase their billings even more. In Pennsylvania, a laboratory agreed to pay $750,000 to settle allegations that it overcharged the State for testing done for drug and alcohol facilities and hospitals in the Pittsburgh area.

HOME HEALTH CARE

Already the fastest growing part of the Medicaid-funded health care system, State and Federal outlays in the home health industry have ballooned in the last 5 years. In 1994, more than 7.1 million people were expected to receive some form of home care. The current Medicaid Federal share for home health care is $4.1 billion and is expected to reach $18.4 billion by the year 2000. This increase is due to an aging population, shorter hospital stays and an increase in technology. Since the I970's, technology has advanced to the point of allowing more and more patients to remain in their homes and receive treatment. The profile of a typical home health care recipient is one who is elderly, disabled, has AIDS, heart disease, diabetes or has been discharged from the hospital and needs more care.

Not only are home health care agencies charged with grossly inflating the number of hours their employees worked, but, more importantly, in some cases with recklessly sending untrained, unqualified, and unlicensed aides into private homes of thousands of critically ill and care-dependent patients. It is an industry that contains all of the components for disaster. It is unregulated in the traditional medical sense, multiple agencies are involved with large amounts of government money and it is attractive to the consumer.

Let me highlight a few examples of the units' work in this area:

Five individuals in Massachusetts were charged on a variety of Medicaid fraud charges as a result of the MFCU's investigation into Medicaid's personal care attendant program which allows disabled individuals to remain in a community setting with the aid of personal care attendants. Each of the defendants charged the State for services which were not provided and/or inflated billings made to the agencies.

Five people in California were paid for up to a year for caring for relatives who had died. These caretakers were also recipients of other government programs. Both they and the program paying them failed to report the offsetting income.

Similarly, in Washington State, two home health care providers continued to bill the Medicaid program after the patients had died. In one of these cases, the defendant continued to bill the State while living with the victim's ex-wife.

A certified nurse's aide in Maine was sentenced to 3 years in jail, with all but 30 days suspended, and to 4 years probation for adding her name to a number of credit cards that belonged to the patient and making purchases on those cards totalling $7,196.13.

The owner and billing clerk of a New York home health care agency were convicted of stealing more than $1.1 million dollars, during a 3-year period for fraudulently billing the State for professional nursing services rendered to thousands of homebound Medicaid patients by these unqualified workers.

A recent statewide audit of New York's Care at Home Program—also known as the Katie Beckett Waiver Program—identified more than $2.4 million in Medicaid overpayments. The audit revealed that during a 4-year period, Medicaid was not only charged for services more properly payable to patients' private insurance policies, but also billed via special codes that bypassed the routine prior approval process and resulted in substantial overpayments.

In one county in California, there are no less than 74 home health service agencies, many of which line up, literally, at board and care homes offering competitive incentives for home health care business within the facility. These agencies are potentially turning board and care homes into health facilities that are virtually unlicensed, noncertified, nonregulated, and practically invisible.

Among the most rapidly growing segments within the home health care industry is home infusion treatments, currently estimated to cost $4 billion.

Home infusion treatments include more than the actual medication. In addition to drugs and nutritional formulas, supplies such as tubing, syringes, alcohol swabs, bottles, gloves, and needles, and expensive equipment such as pumps, nebulizers, glucose monitors, and blood pressure kits that are regularly utilized by the victims of these serious illnesses, all of which are billed on a regular basis. A large amount of the funds, too, are spent in the area of home care services. Regular visits, frequently more than once a day, by an R.N., nurse practitioner, home health aide, a physician's assistant, or even a physician, are required and reimbursed. Further, regular visits to a physician for certification of continued need and dosage adjustment are necessary. Again, a classic recipe for fraud with fragmented billings; drugs are billed by the pharmacies; the supplies used to assist in administering the drugs are billed by the DME provider; professional services are billed by the home health service company or individual providers; and personal services may be billed to various agencies. In California, Medicaid block grants are given to counties who pay in-home services out of various funding sources.

The potential for fraud in this rapidly expanding and highly expensive industry is clear. Kickbacks to doctors to authorize medically unnecessary treatment, services, or supplies, whether provided or not, is cause for MFCU concern.

Several multibillion-dollar home health care corporations are currently the subject of both Federal and State investigations.

MEDICAL TRANSPORTATION

Virtually every State MFCU has found egregious examples of fraud by nonemergency medical transportation companies. Medicaid will generally pay for a patient's transportation to a medical provider either when mass transit is unavailable in the recipient's area or when the patient, because of a debilitating physical or mental condition, cannot use this method of transportation. Examples of medical transportation fraud include: billing for an excessive number of miles per trip for services actually provided, billing for recipients who drove themselves, paying kickbacks to recipients who used the medical transportation services, allowing noneligible persons to use another recipient's card, submitting falsified appointment dates for round-trip transportation services to a provider's offices, charging billing for emergency transportation for nonemergency situations, billing for fictitious services not covered by the Medicaid program or for transportation that was not pro-

vided, and creation of phony certificates of need ostensibly by doctors, and kickbacks to doctors for improperly certifying the need.

Transportation fraud is also committed by ambulance providers as well. For example, in Pennsylvania claims were filed to the State requesting reimbursement for ambulance trips that were not medically necessary. Many of these trips were to doctors' offices, which are not reimbursable under Medicaid regulations, but were misrepresented as being trips to hospitals. A Minnesota company that provided ambulance and medical transportation reached a $3-million setllement with State and Federal authorities for falsely billing the Medicaid and Medicare programs. The company billed these programs for basic life support ambulance transportation, claiming that the rides were medically necessary, when a lesser form of transportation would have been adequate.

The general transportation program in Maryland virtually collapsed under the weight of fraud and abuse. In 1988, the program cost taxpayers $4.5 million per year. Fraud, abuse, and aggressive marketing caused the demand for program services to increase fourfold in 4 years, for a cost of $16.2 million in 1992, at which time this benefit was severely restricted.

In California, a State that pays for almost no transportation services, nearly $1 million was recovered from bank accounts hours before the money was to be transferred out of the country. The defendants had already fled. They had used a combination of phony certificates of need, lying about the mileage and kickbacks to board and care operators for access to Medi-Cal patients.

DRUG DIVERSION

In the early 1980's, the diversion of legal drugs for illegal purposes in the Medicaid program frequently involved pharmacists filling prescriptions with generic or other cheaper substitutes for the more expensive, brand name drugs that were being prescribed by physicians or submitting false Medicaid reimbursement claims for higher-priced, brand name medicines. Since then, drug abusers have turned to prescription drugs as their drug of choice and this demand has generated a supply of dishonest health care providers who both abuse their prescribing privileges and incur great costs to prescription plans, such as Medicaid. In large urban centers, it is not uncommon to find a so-called pill mill which has as its primary purpose the issuance of prescriptions for controlled drugs in exchange for cash or, in some cases, sexual favors. These drugs may then be resold on the street or sent abroad for black and gray markets for several times their cost, sustaining the continued addiction of countless individuals. In some instances, we have found that the street addicts resold the prescription drugs to other pharmacies at a fraction of their original cost and at some risk to the unsuspecting customers of the second pharmacy.

In a typical scenario, a "patient" will visit an unscrupulous doctor and buy, for instance, a prescription for 90 valium at about $1 per pill. After "busting" the 'scrip—having it filled—at an accommodating pharmacy, the patient will resell the pills to individuals at $5 a pop and thereby net a profit of $360. Not factored into this economic equation, however, is that each participant in the scheme is sustaining the continued addiction of countless individuals.

In Texas, for example, as in a number of other States, the drug diversion problem is most commonly seen in the following schemes:

1. A Medicaid recipient goes to a doctor's office and pays cash for a controlled drug prescription, which is then filled by a pharmacy. The doctor does not bill the Medicaid program, the pharmacy does;

2. A middle man—that is, nonrecipient—goes to a doctor and gives him cash for a number of prescriptions for controlled substances with no names or addresses on any of the prescription forms. The middle man then rents Medicaid cards from recipients, inks in the blanks on the forms, and goes to a pharmacy to have the prescriptions filled. The pharmacy bills Medicaid;

3. A Medicaid recipient goes to a doctor for a legitimate medical reason and the doctor gives the recipient a legitimate prescription. The recipient is approached outside the doctor's office with an offer to buy the prescription. The recipient often sells the prescription. A business arrangement is then established.

Medicaid prescriptions alone cost the government $5.5 billion in 1991, a cost that is expected to nearly double by 1996 to $10 billion. These costs are not confined to the actual reimbursement for the drugs dispensed, but rather include much greater costs which society must absorb from the continuation of the addiction cycle and its ensuing impact on the health of the individual. According to a study released on July 15, 1993, by the Columbia University Center on Addiction and Drug Abuse, $4.2 billion of the $21.6 billion paid by Medicaid for hospital care in 1991 was for care attributable to substance abuse. If one applies that same ratio—just under 20

percent—to all U.S. health care expenditures, this Nation is spending nearly $200 billion a year on care attributable to substance abuse.

HIT AND RUN

The larger point-of-entry cities of the United States have noted so-called hit-and-run schemes in which foreign nationals fraudulently obtain a Medicaid provider number and then submit invoices for services not rendered. In larger cities, these fake providers often are able to obtain hundreds of thousands of Medicaid dollars before their detection, at which time they flee to their homeland. In one such case in New York, the perpetrators went so far as to establish a medical laboratory and then offer to buy the blood of Medicaid patients for $10 a pint. Once the owners of the laboratory obtained the blood and the Medicaid eligibility numbers of the patients, they would submit astronomical bills to Medicaid, representing that they had performed an extensive and costly blood work-up, the results of which the patients would not receive. The laboratory owners were discovered only when numerous "patients" began appearing at hospital emergency rooms after selling excess amounts of blood and rendering themselves gravely ill.

FRAUD IN MANAGED CARE

Both the Medicaid and Medicare programs are utilizing managed care delivery systems. In some States, managed care has been in existence since the early 1980's. Currently, more and more States are requiring greater numbers of their Medicaid population to participate in their managed care programs.

Proponents of the managed care system believe that it is the best method for providing low-cost, high-quality health care to more people. Managed care is supposed to save money not only in the delivery of services but by reducing the amount of paperwork. While many observers point out that the very nature of managed care prevents fraud, the experience of the fraud units, the Arizona unit in particular, the Medicare program and the private insurance industry, reveal that no health care plan is immune from fraud and indeed fraud does occur in managed care plans. Rather, fraud simply takes different forms, in response to the way the program is structured.

While the traditional Medicaid provider fraud investigation focuses on overutilization of services and fraudulent billing, in managed care investigations, the evil more likely lies in the underutilization of services. Financial considerations will cause some unethical providers to render less care to, or disenroll, the unhealthy patient. Unlike the typical Medicaid provider fraud case, the human cost in terms of reduced access to quality care may be tremendous.

The MFCU's have documented certain types of criminal activity in managed care plans. Fraudulent subcontracts, fraudulent related party transactions, excessive salaries and fees to the entrepreneurs involved, bribery, tax evasion, kickbacks, rebates, and other illegal economic arrangements, and fraud in the administration of the program. Quality of care problems such as the underutilization of necessary services, falsification or misrepresentation of professional credentials, and the use of unlicensed providers may occur more frequently in managed care programs than in the traditional fee-for-service payment program. Further, instead of billing numerous unnecessary procedures for a few existing clients, physicians may legally increase their income by agreeing to provide care for hundreds or even thousands of clients for monthly capitation fees. The patients become a captive audience, and the physician has less incentive to find sufficient time to provide good care for his patients.

One Maryland case illustrates one kind of fraud and patient neglect that will be a problem faced by managed health care programs in future years. The Maryland Medicaid program has initiated a limited managed care approach which pays physicians a minimal monthly fee for each patient for whom they assume primary responsibility. The Maryland MFCU recently prosecuted a physician who "treated" between 90–100 patients a day, recording for each patient the identical blood pressure and pulse rate, and using a rubber stamp to diagnose the same ailment for most. The amount of his Medicaid payment was based upon his rendering a "comprehensive" medical examination for each patient. The sad truth was that his patients received no medical care and, in several cases, suffered from conditions that worsened due to his neglect. When questioned by MFCU staff, he was unable to provide the name of a single patient for whom he allegedly provided care. The physician was convicted of felony Medicaid fraud.

In California, the State enrolled 1.1 million Medi-Cal beneficiaries in 1993 and expects to have 2.5 million beneficiaries—or 50 percent of the Medi-Cal population—

enrolled by early 1996. Bids for contracts with health care service plans, commonly called HMO's, are being reviewed at this time.

In California's managed care system, the single State agency—Medicaid agency—contracts for some or all of its Medicaid covered services and supplies. The contractor is most often a coordinating business entity, not an actual provider. The services are rendered by employees of the contractors or by subcontractors. The victim of fraud may be the program, the contractor, the subcontractor or the individual provider. The perpetrator of fraud may be an individual within the single State agency, the contractor, an employee or agent of the contractor or subcontractor, or individual provider, or even a related entity that controls the service provider. An example of this is found in the Arizona experience.

The Arizona Health Care Cost Containment System [AHCCCS], a statewide prepaid capitated program, began on October 1, 1982, and was the first in the country to offer its citizens a managed care program. The AHCCCS fraud unit was established 2 years later. That unit has extensive experience in investigating fraud in managed care.

In one Arizona case, three former officials of one of the largest health care providers under the AHCCCS program were indicted on charges of fraudulent schemes, conspiracy, theft, and illegally conducting an enterprise, Health Care Providers of Arizona [HCPA]. The three were charged with conspiring to defraud HCPA and AHCCCS by diverting funds lawfully belonging to HCPA to themselves and their businesses. The investigation revealed that the moneys were taken out of HCPA in various fraud schemes and thefts in the guise of capitalization, management fees, medical directors' fees, bonuses, medical equipment, and excessive rental charges. Two of these individuals, a licensed doctor of osteopathy and a medical doctor, both pleaded guilty to one count of fraudulent schemes, and two counts of facilitation of theft. Both were sentenced to 3 years probation and ordered to pay a $14,000 fine, $50,000 in restitution, and $50,000 in costs of prosecution. A registered nurse implicated in the scheme pleaded guilty to two counts of facilitation of theft, and was sentenced to 3 years probation, and ordered to pay a $5,400 fine, $5,000 in court costs, and $4,556 in restitution.

As the experience of the State MFCU's demonstrates, fraud does occur in managed care plans. As health care delivery systems become bigger and bigger business, not only will unscrupulous providers find new and innovative ways to criminally profit at the expense of patients and health care payers but so will enterprising businessmen and women.

MULTISTATE/FEDERAL COOPERATIVE EFFORTS

Cooperative efforts between State and Federal authorities have proven very effective in protecting Medicaid and Medicare from health care providers or vendors whose activities involve both programs and cross State lines. Joint Federal and State task forces have been established in States throughout the Nation, and agents increasingly are working together to detect fraud against government insurers. One side effect of these efforts has been the recognition by seasoned defense attorneys that all parties must be at the table when any case resolution is discussed. A settlement reached with a State Medicaid Fraud Control Unit in which all Medicaid claims are resolved, for example, does not necessarily resolve those in other States or any outstanding Medicare claims or their attendant sanctions. The result has been an unprecedented willingness on the part of State and Federal authorities to reach "global" settlements in which all outstanding claims by government insurers can be resolved, and in which all administrative sanctions can be addressed. Mechanisms are now in place in most States which facilitate the prompt resolution of Federal and State claims, and the MFCU's themselves have developed uniform procedures to coordinate joint efforts in resolving Medicaid-related claims arising from interstate providers through the National Association of Medicaid Fraud Control Units.

For example, last year, the Department of Justice announced that a settlement was reached with NME Psychiatric Hospitals, Inc., which manages more than 60 psychiatric hospitals and substance abuse centers nationwide. NME Psychiatric Hospitals is a wholly owned subsidiary of National Medical Enterprises, [NME] Inc., which is headquartered in Santa Monica, CA.

In the largest multistate agreement of its kind, 27 State Medicaid Fraud Control Units and the District of Columbia negotiated a final settlement with NME for $16.3 million. The charges were based on NME Psychiatric Hospitals' payment of kickbacks to doctors, referral services, and other persons so that they could refer patients to NME hospitals. The patients were insured under such government health programs as Medicare, Medicaid, and the Civilian Health and Medical Pro-

gram of the Uniformed Services [CHAMPUS] and the Federal Employees Health Benefit Program.

NATIONAL ASSOCIATION OF MEDICAID FRAUD CONTROL UNITS [NAMFCU]

The National Association of Medicaid Fraud Control Units [NAMFCU] was established in 1978 to provide a forum for the nationwide sharing of information concerning the problems of Medicaid fraud control, to foster interstate cooperation on law enforcement and Federal issues affecting the MFCU's, to improve the quality of Medicaid fraud investigations and prosecutions by conducting training programs and providing technical assistance for association members, and to provide the public with information on the MFCU program. All 45 MFCU's comprise the association.

The association employs a Medicaid fraud counsel, located at the National Association of Attorneys General in Washington, DC. The association coordinates and disseminates information to the various units, maintains a library of resource materials, and provides informal advice and assistance to its member units and to those States considering establishing a unit. NAMFCU conducts several training conferences each year and is called upon regularly to supply speakers for numerous health care fraud seminars. It has also cosponsored training programs with the FBI and the American Bar Association and conducts a specialized academy at the Federal Law Enforcement Training Center. "The Medicaid Fraud Report," published 10 times a year, is the association's newsletter. The newsletter contains information concerning prosecutions by various States, reports of legal decisions affecting fraud control prosecution, and analyses of legislation affecting the Medicaid program and the units. NAMFCU also serves as a clearinghouse for State/Federal cooperative efforts and provides a responsive voice to congressional inquiries.

MEDICAID FRAUD CONTROL UNIT FUNDING

Under current legislation, units are funded with 75 percent Federal funds and 25 percent State matching funds on a yearly grant basis except for the first 3 years of a unit's operation when a unit receives 90 percent Federal funding. The 90-percent Federal funding provides an incentive for establishing a fraud control unit and is also intended to provide a new unit sufficient time to become fully operational. The Federal match is part of the Medicaid program's administrative costs, which are contained in the budget of the Health Care Financing Administration [HCFA]. The funds for the fraud control units are subsequently transferred to the HHS Office of Inspector General [OIG] for distribution to the States. OIG has administrative oversight responsibility for this grant program and certifies and recertifies the units to insure that they comply with Federal regulations.

We believe that maintaining program integrity factors are essential if any changes occur in the structure of the Medicaid program. State Medicaid fraud enforcement should continue to be a Federal priority in the States' administration of their Medicaid program. Funding for the State Medicaid Fraud Control Units should continue to go to their sponsoring agencies and should not be included as part of a larger Medicaid grant that is distributed to the States.

This would maintain the separate and distinct character that has made the units successful in detecting and prosecuting Medicaid fraud. Federal oversight should continue to be vested with the Office of Inspector General of the Department of Health and Human Services to maintain law enforcement sensitivity on oversight issues.

Separation of MFCU's from the Medicaid agency was considered a critical component of Public Law 95–142, which created the State Medicaid Fraud Control Unit Program. Congress recognized that law enforcement functions can best be accomplished by law enforcement agencies. Further, in analyzing the reasons for the Medicaid agency's failure to adequately police the program, Congress recognized that there were inherent obstacles. For example, the responsibility of administering the program necessitates a close association with the provider community. This is incompatible with and detrimental to the policing function.

The MFCU program has many of the currently discussed characteristics of a block grant program. Most significant is the States' ability to adopt individual enforcement approaches. The philosophy of current Federal grant oversight is to require each State to maintain the resources necessary to operate an effective and efficient Medicaid Fraud Control Unit. We strongly urge that this practice continue and be a requirement for any future block grant programs involving Medicaid.

If the Medicaid statute is rewritten to block grant Medicaid funds, we believe that the following requirements for State MFCU's, while not all inclusive, should be maintained:

Federal grant oversight by OIG/HHS;
Separate and distinct unit status from the State Medicaid agency;
A strictly defined mission statement reflecting current grant oversight requirements;
Funding and authority to continue patient abuse investigations and prosecutions;
The unit should be a single identifiable entity with staffing by experienced attorneys, auditors, and investigators; and
Unit funding levels should be maintained.

The Medicaid Fraud Control Unit Program has been a successful example of an enforcement cooperative activity. If the old saying, "if it isn't broke, don't fix it" has any applicability, it does here.

In closing, I want to emphasize that the Medicaid Fraud Control Units are viewed as having a national leadership role in detecting and prosecuting fraud and abuse in government-funded health care programs. The units have been successful in serving as a deterrent to health care fraud, in identifying program savings, removing incompetent practitioners from the health care system, and in preventing physical and financial abuse of patients in health care facilities.

Mr. Chairman, I want to thank you for this opportunity to testify today and would welcome any questions you may have.

Chairman KASICH. We appreciate the testimony of all three gentlemen. We have a problem. We have a vote on. Are any of you under constraint here? If you are, OK, then what we will try to do is ask a couple of questions and then we will go vote and come back.

Let me just ask you a couple of questions. I am not convinced that putting 349 cops out, all over America—I mean this is ridiculous, you cannot do this. It is like trying to catch raindrops. Do we not need a systemic change? In other words, Mr. Anderson says, well, you know, we have these problems with these HMO's and these people are being—I mean there is an element is there not where people have to know they are not being treated properly?

I mean people can judge that? Do we not need to get systems in place where we have systemic change to fix this as opposed to how many agents we can put out in the field?

These cases are very complicated. There is a zillion of them going on. You could not have enough people out there trying to audit all of this. First of all react to that, and secondly, what would you do to systemically change it?

Mr. MANGANO. Well, you are absolutely right. More than half of the activity that we devote our time to is toward audits and evaluations of the programs of the Department. We are trying to find those systemic stops to the problems that exist out there.

So far, I think we have been fairly successful in identifying problems in the early——

Chairman KASICH. We have 7 minutes. We will go vote and come back and we will not keep you real long. Let us go and do that.

[Recess.]

Chairman KASICH. Why do we not go back to the issue of system changes, as opposed to trying to catch every problem that may be out there.

Mr. MANGANO. I think I was beginning to talk about one of the ways in which we approach it. Right now we are clearly in pay and chase mode where people will rip us off; and then we have go to find them and bring them to the court of justice.

We have also spent a lot of time, however, trying to look at the systems that are out there and try to preclude some of these problems from occurring. As an example, in the Medicare program, pro-

vider numbers are the key to being able to bill the Medicare program.

We have been doing a lot of work in that area to strengthen the way that the Medicare program takes a look at entrepreneurs who want to do business with the Medicare program. If you can build in those system edits at the front end, that helps.

A second way to build system edits is in the entire payment process. When we are dealing with hundreds of millions of claims a year, it is awfully difficult for the Medicaid program or the Medicare program to catch the crooks. Because of that, we look for the big blips in the system.

I will give you one example of that: the incontinent supplies for people who have urinary and bowel problems. In 1990, the Medicare program was paying $88 million. In 2 years that tripled to over $200 million. Our investigations into that area alone have shown that about half of that is fraudulent. Because the supplies are being billed by people who are supplying things like diapers instead of female urinary collection pouches and other legitimate devices. It must be a prosthetic device, not a throwaway item like that to be covered by Medicare.

In the home health agency which came up here a little earlier, we are seeing tremendous growth. Medicare paid $3 billion in 1990, and it is up to $16 billion this year—a fivefold increase.

People are getting involved in this process. So, clearly the best advantage is to put system edits into the early part of the process and catch them and prevent them from occurring. But there are lots of opportunities when you think about 33 million Medicaid beneficiaries, and more than that in the Medicare program.

Chairman KASICH. Folks, I am sorry to be in and out so much today, but I have no choice. I have to go to another meeting and I will let Mr. Shays chair the meeting, but I am sorry that it has been in and out, but we are just trying to get our work done and I have got to go.

If you will let the other two gentlemen answer that question and then you guys can ask questions and wrap it up.

Mr. POMEROY. Mr. Chairman, I have another committee starting now as well and I would just like to follow-up on the chairman's question with a brief one. I thank you for your information today. I think it has been excellent.

The question that the chairman has asked is the systemic ability to identify fraudulent practices and it seems to me that insurance companies have attempted to track utilization blips that do not make sense. You just indicated one that was recently discovered. Has HCFA reimbursement systems developed an ability to track utilization fairly closely based on what they are spending?

Mr. MANGANO. They can do that fairly well in the Medicare program, where we have a national data base that is maintained by HCFA. We have access to that data base so we can see those blips. I mentioned two of them. Many items are durable medical equipment like seat-lift chairs, power-operated vehicles, or body jackets, et cetera.

HCFA tracks billing fairly well in the Medicare program but the data, by the time we get it, is, of course, going to have a lag time

of 6 months to a year. So we are going to catch the problems shortly after they occur, but after they occur.

The Medicaid program is a whole different story. In terms of payments nationally, HCFA is really very far behind on Medicaid and is relying on data that really is not as good as what is in the Medicare program.

Individual States have individual situations with regard to their payment data.

Mr. ANDERSON. And I might just add, Mr. Chairman, and members of the committee that the individual States have developed something called a SURS unit for each State. In fact, that is mandated by Federal law. It stands for Surveillance Utilization Review Subsystem. Very briefly, what that means is that each State has a very advanced computer system that has edits built in. So that every claim submitted by a provider is compared to all other like providers.

So a pediatrician in Baltimore City is compared to other pediatricians in Baltimore City and when there is a statistical anomaly within that data, the computer will spit that person out. Then a doctor employed by Medicaid will sit down and look at those records to make sure there is no logical reason for why there is this anomaly and if there is a problem with it they will send it to the fraud unit.

Mr. POMEROY. Has that produced substantial savings?

Mr. ANDERSON. It produces about 40 percent of our referrals. I think, over and above that, what happens typically is if they do not find fraud they at least contact the health care provider and say, you are way out of whack here what is going on? Then the provider either has an explanation or he does not. Then money is retained or somehow is retrieved back to the Medicaid program.

I would say it has substantial savings.

Mr. KUBIC. I would just like to add the fact that in the private sector the development of electronic fraud detection is an ongoing process. Not only in health care fraud, but in credit card fraud, in bank fraud, and examinations. So that the private sector is very conscious of the need to use audits, internal audits to identify potential fraud.

And I think that is what you are seeing in both the State and Federal system. It really does refine your utilization of resources so that instead of agents being involved in looking for criminal investigations, there is a built-in system that can say, this is what is going on so that we have a much better opportunity to successfully pursue those individuals.

Mr. POMEROY. If I might ask a final question and then I am taking off.

The thrust of your testimony today, as I understand it, is that if Congress should consider a block grant approach to Medicaid you believe that we should continue some directive relative to fraud enforcement?

Mr. ANDERSON. Very much so, sir. Just as anecdotal evidence, when every year I have to go to my State legislature to get funding, I am not a terribly popular person down there. Most States have part-time legislatures consisting of defense lawyers and, in some cases, health care providers, and a fraud effort on the part of the

State which produces prosecutions against doctors is not very popular with that crowd.

So I have trouble coming up with the 25-percent matching grant every year to fund my unit on the State side. I can tell you that if you were to block grant each State X amount of dollars to fund the Medicaid program and included in that amount was funds intended for an antifraud program, most States would choose to take the money and provide direct patient care instead.

Fraud issues are not of primary importance to Medicaid agencies. Of course, they want to police fraud, but on the other hand, it is much more important to make sure that they enroll doctors, that they have sufficient medical care for their poor and fraud is somewhere pretty low down on the ladder.

In my testimony we have requested very specific legislation that will say we are completely independent from the Medicaid block grant. But if you are going to block grant these moneys, make sure there is a provision that says, here is X amount of dollars that must go to maintaining an antifraud effort in your State, preferably a Medicaid Fraud Control Unit.

Mr. POMEROY. The net result of that is literally billions of dollars of savings.

Mr. ANDERSON. Absolutely. It is hard to quantify the deterrent impact that we have. We can tell you that we collect hundreds of millions of dollars in fines and restitution, but on top of that the health care community knows there are people out there policing these services, so I hope they are being more careful.

Mr. SHAYS [presiding]. Thank you, gentlemen. I have not heard your testimony. I chair a subcommittee on government reform and that is where I was. But I also have a responsibility in Medicaid and Medicare in this committee and the task force.

You will all be invited to come before our committee as it relates, it is the Human Resources Subcommittee on Government Reform and we oversee HHS. We are really trying to decide where we focus our time and attention.

If it has already been inserted in the record or if it is in your testimony and so on you do not have to give me a long answer, but if I look at Medicaid, do I find more abuse in health care for the poor or more abuse in nursing care for the elderly?

Mr. ANDERSON. You see us all hesitate because it is so hard to quantify fraud. My experience has been I have prosecuted far more cases in health care for the poor. We have a number of systems checks set up now in terms of nursing home care for the elderly that I think is preventing a number of these fraudulent schemes.

I caution you, however, that it is always dangerous to ever try to quantify fraud, because just as sure as we are sitting here, someone else out there is devising a new scheme that is going to result in much more money being lost to Medicaid that we just are not on top of yet.

Mr. KUBIC. Yes. I agree. I think the FBI's observations would be that we have seen much more abuse in the area of the poor on that side, rather than nursing homes. My experience goes back to the nursing home in 1977 and it has been a problem, I believe, for as long as that or at least that was my first experience.

I do not think the nursing home problem is fixed at all. I am just saying that the ease of access that we see in the schemes devised today are such that is a broader area.

Mr. MANGANO. I would have to agree with the last statement. Most of the fraud that we are seeing is not inside the nursing home or related to that, but rather to the services provided to the poor, the elderly and the disabled.

The reason, I think, is that with the nursing homes, at least you have an oversight mechanism that comes in to review the nursing homes on an annual basis with State survey agencies. They are required to adhere to a variety of laws at the Federal and the State level; and they get marks on those reviews each year.

So there is an oversight capability built into it, but there is no such analogous situation with individual providers that are providing health care services to the poor. A physician, an ambulance company, chiropractor, any one of those folks who wants to do business in the Medicaid program can basically do it, if they just meet minimal requirements for State licensure and any other requirements that the State has.

It is almost impossible for the States to really keep tabs on all of the providers that are providing services until they find somebody becomes an aberrant provider.

Mr. ANDERSON. I just want to add, I think you were absent for part of my testimony but——

Mr. SHAYS. I was absent for all of it.

Mr. ANDERSON. About 40 to 45 percent of all the cases done by the Medicaid Fraud Control Unit statewide involve patient abuse and neglect in Medicaid funded facilities, typically in nursing homes. Not fraud, but it is usually physical crimes committed against the Medicaid patient in a nursing facility.

Mr. SHAYS. It is interesting where fraud ends and just abuse begins. I mean it is probably fraud but you cannot send them to jail.

Mr. ANDERSON. Fraud in the sense that they are not rendering the care that we are paying for.

Mr. SHAYS. When you find an egregious case and it is being prosecuted, are you basically satisfied with the disposition by the courts, or give me an example of what would not satisfy you of a case?

Mr. ANDERSON. I will tell you very candidly, that the typical health care provider is a first time offender. It is a white collar criminal offense. It does not involve violence and the result in most States, with an overcrowding situation that we have in our division of corrections is that they do not go to jail.

And I think that is an unfortunate circumstance of a number of factors. I think it is different on the Federal level. For the most part they have much tougher Federal sentencing guidelines. They do not face the overcrowding issues that we face on the State level.

On the other hand, I can tell you it is very difficult to get a first time nonviolent offender in jail.

Mr. SHAYS. Even if it is sizable dollars?

Mr. ANDERSON. Well, the more the dollars are, the more likely it is the doctor will go to jail.

Mr. SHAYS. Give me an example. Because they are a pillar of the community kind of response, that is their first offense, and they have their college degree and they went on to graduate school.

Mr. ANDERSON. Well, it is more along the lines of we just had this guy over here who held up a bank with a gun and we do not have room in jail for him.

Mr. SHAYS. Right.

Mr. ANDERSON. So we are not going to make room for this physician who robbed with a pen. He does not represent a threat to society. He lost his medical license. He is not going to go out and commit a violent crime.

Mr. SHAYS. In a lot of the cases do they lose their medical license?

Mr. ANDERSON. Yes. In almost all cases in my State and I think in most States a crime of Medicaid fraud is automatic suspension.

Mr. SHAYS. Suspension is different than losing it.

Mr. ANDERSON. I know and usually I would say they lose their license for no more than 2 or 3 years unless their conduct was totally egregious. But I have a guy that I prosecuted 4 years ago who ran a nursing home and allowed his patients to fall into such disrepair that some of them lost limbs because they were so filthy and had not been maintained by him. We prosecuted him, and we got 2 years in jail which is an extraordinary sentence and last week they gave him his medical license back.

So that is a frustrating aspect of my job.

Mr. SHAYS. He spent a year in jail and then——

Mr. ANDERSON. He spent a total of 11 months in jail and now he is out today practicing medicine.

Mr. SHAYS. Anyone have any comments?

Mr. ANDERSON. Fortunately though I will add that they cannot be enrolled in the Medicaid and Medicare program. The Medicaid program for 10 years and the Medicare program for 5 years, and then they have to apply for reinstatement. So by shutting them out, someone like him, by shutting him out of those two programs, we are effectively denying him the practice of medicine because almost all elements of the practice of medicine these days involve one of those two insurers.

Mr. MANGANO. I would say that in the last year we excluded from the Medicaid and Medicare program over 1,300 individuals because of crimes against the program. You must remember when we investigate a case——

Mr. SHAYS. Excuse me, can they go somewhere else and practice?

Mr. MANGANO. They cannot practice in the Medicaid or Medicare or State-funded health care programs. They could still provide services to the private sector unless the State medical board takes away their license, in the case of a physician, or licenses are taken away for other kinds of providers.

Whenever a U.S. attorney decides to prosecute a case or a State attorney general decides to prosecute a case, they will only prosecute on those charges that they believe they can clearly win their case on.

I think in many of the investigations we get involved with, we find clear instances that we believe the U.S. Attorney will clearly prosecute. But there are a lot of other instances that we suspect

the wrongdoing was done, but it will be very difficult for us to prove. We do not want to have too long a list if we cannot prove them in court.

I think there is always a little bit of dissatisfaction particularly in the larger cases that enough justice was not done.

Mr. SHAYS. Mr. Kubic.

Mr. KUBIC. Yes. Generally in our violent crimes program which would include bank robberies, extortions, kidnappings and so on the average subject who is convicted in Federal court is sentenced to about 8-to-10 years in jail.

In contrast to that the average white collar crime subject who is convicted does a little bit more than 2 years. That is consistent with the current Federal sentencing guidelines but it does underscore the issue that you raise.

Mr. SHAYS. But particularly if someone is able to rob a bank without a gun, and takes $10,000 or $20,000 and then someone is ripping off the system for $80,000 I consider that—and there I do share in my sense they have an ethical responsibility.

My challenge as someone who is helping to write laws is that every time "60 Minutes" or "20–20" or "48 Hours" shows some abuse we respond by trying to find a way to prevent that abuse and then the regulations just grow and the red tape and so on.

So it is really a tradeoff. I have come to the conclusion that in some ways the simpler the better and if people rip off the system then you nail them as hard as you can nail them.

Do you understand the tradeoff? I mean with all the new TV programs and some of us will get constituents who will write us and say, how can you let this happen and then we try to prevent it from happening. It is the same thing we did with our tax codes.

Just to extend this a little bit longer, I know you are here for Medicaid but do some of you get on both sides of the issue, Medicaid and Medicare?

Mr. MANGANO. We do.

Mr. SHAYS. As a general rule, do you find more abuse in Medicaid or Medicare?

Mr. MANGANO. I think it would be very difficult to draw a line there. There is so much abuse in both programs that I do not think I could render a judgment that one is more abusive than the other.

Mr. SHAYS. Is there a way that a committee of Congress that if it decided to just devote a lot of time and energy on this, could really highlight the abuse with the motivation of bringing reform?

Is there any contribution a committee could make that because of the work that you do it does not get public attention, it does not get any focus, it is ignored?

Mr. MANGANO. I think what the committee can do is shed the light——

Mr. SHAYS. I am not thinking of this committee. I am thinking of my other committee. My subcommittee could spend a lot of time on this issue.

Mr. MANGANO. I think the value that your other committee, before which June Brown and I testified a couple of weeks ago, could have is to shed the public light on some of these abuses and give a public forum showing how difficult the problems are and raise possibilities for solutions. Not just with people like ourselves, but

with administration representatives like representatives from the Health Care Financing Administration, to work with us to come up with system changes to prevent these abuses from occurring in the first place.

I think there are a lot of areas that are vulnerable to fraud and abuse, and we have got to close them off. But we have got to do it with the law enforcement working along with the agencies that have responsibility for oversight, in addition to the oversight responsibility of the Congress.

Mr. SHAYS. What is the worst thing the Federal Government has done to help root out fraud and abuse in Medicaid in the last 5 years and what is the best thing it has done?

Mr. MANGANO. Some of the things that are put into law just leave tremendous opportunities for misspent funds. For example, there are things like what occurred in disproportionate share and taxation and donations which were totally legal practices by State Medicaid agencies and State governments. The Federal budget lost about $17 billion in that deal. It was an effort to assist——

Mr. SHAYS. That is $17 billion?

Mr. MANGANO. Yes, disproportionate share went up from under a billion dollars to $17 billion in a relatively short period of time. And these were schemes that States were able to use to match Medicaid money.

Mr. SHAYS. We have exempted some States from this now. I mean some States are given a windfall.

Mr. MANGANO. The law has changed, and a lot of that is cut off, and more of it will be cut off.

Mr. SHAYS. But my sense is that some States are allowed to continue this practice and other States are not allowed to, is that correct?

Mr. MANGANO. My understanding is that every State is precluded from most of the activity that was going on there. There are still one or two loopholes that are left, but time is running out on those.

Mr. SHAYS. OK. The worst thing and the best thing, gentlemen.

Mr. KUBIC. Boy, that is a tough question.

Mr. SHAYS. Is that because we have made too many mistakes?

Mr. KUBIC. Well, no, not really. I think one of the best things that has happened is the funding of the antifraud efforts that you have done. What I have seen is basically a system that is interested in providing for the welfare of the people in a virtually unchecked way so that the people that we deal with on a daily basis that are criminals look at that system and they will exploit it and there are many ways to exploit it.

So the Congress and the U.S. Government have got to recognize that those people are going to do it, and they do it on a daily basis, whether they are organized crime subjects, or white-collar crime subjects. There has to be a credible enforcement effort to prevent that activity.

You have to basically fund antifraud activities and if it is the Medicaid Fraud Control Units who are very close to the problem because they are operating in unique States and Territories or if it is the HHS–IG, or if it is the Bureau, I think it is absolutely essential.

In terms of the worst thing, I just cannot think of one at this time.

Mr. SHAYS. Can you think of a few?

Mr. KUBIC. No, nothing comes to mind.

Mr. ANDERSON. I was hoping you would forget me. I will never understand, as I do these cases, I do not think I will ever understand how it is that the Medicaid program will pay for benefits that I am not entitled to at Blue Cross/Blue Shield.

I realize that is probably a direct criticism of my State and other States that are——

Mr. SHAYS. No, but elaborate on this.

Mr. ANDERSON. I will. For example, mental health care. I think mental health care is a vital aspect of providing health care to people but in my State it is not limited. Someone can go and receive mental health counseling to any degree they wish.

General transportation, which I talked about in your absence, but we actually paid to transport people by taxi to their health care providers which most States do.

Mr. SHAYS. Is this Maryland that does this?

Mr. ANDERSON. It is Maryland but it is most States.

Mr. SHAYS. I will tell you that I decided not to have an auto down here after having one for a while and I use a taxi to go back and forth. And there is this gigantic notebook that the taxicab driver has and I asked him what is it, he said these are all the clients that I have to pick up, that my company picks up. They negotiated a contract. And he said it is a gigantic rip-off. He said, it just blows his mind what the government pays in transportation.

Mr. ANDERSON. You know, I do not mean this as a slam against all taxi drivers, but I can——

Mr. SHAYS. It is a slam against the government that is subsidizing this.

Mr. ANDERSON. We paid, I think, 95 cents a mile and it has just invited abuse. We have eliminated that program because of the abuse but not before we lost tens of millions of dollars.

There are certainly going to be times when Medicaid people need to be transported to and from their doctor's office because they just cannot get there. But that is not true in most urban centers. We can buy them a bus pass or a metro pass and I think that would suffice assuming they are ambulatory.

Instead the States are more concerned with getting the Federal share into their States than they are in policing the system. That is another reason why we think we have to be independent from those people that are making those decisions because their concern is rendering care and getting Federal dollars.

Mr. SHAYS. We have been joined by Nick Smith who I have a contest on who is going to lose the most weight and for the record, we have both gained weight. [Laughter.]

So I invite my colleague to keep eating and he has the floor.

Mr. SMITH OF MICHIGAN. Mr. Chairman, thank you. I see you have an apple there for lunch.

[Laughter.]

Mr. SHAYS. I suspect there is a fine line between fraud and mistakes, but have you evaluated which is greater, the fraud and mistakes on the part of the providers or the part of the claimants?

Mr. ANDERSON. I think in terms of dollar figures it is by far the providers. The recipients are not in a position to cheat the government out of that much money per se. An individual provider, I mean we heard today of an example of National Medical Enterprise which stole $378 million and that is extraordinary but it takes a lot of recipients to catch up to a figure like that.

I think our typical prosecutions of health care providers on the State level are between $50,000 and $150,000 per provider.

Mr. SMITH OF MICHIGAN. And everybody agrees?

Mr. MANGANO. Absolutely.

Mr. SMITH OF MICHIGAN. Would any of you care to project an estimated cost of fraud in the Medicaid system?

Mr. MANGANO. Earlier today Mr. Bowsher relayed their estimate of 10 percent of health care costs are attributable to fraud or abuse, and abuse would be the larger category; not the fraud. I do not think anybody knows. We are all just guessing. The problem is you do not know fraud until you actually see the case. This 10-percent figure might be correct but I think there is no empirical evidence that would answer that question.

Mr. SMITH OF MICHIGAN. Is there any attempt to get empirical evidence?

Mr. MANGANO. How do you know how much fraud is out there until you find it? There is just no way to make an estimate like that. So what we end up relying on is our experience in working with the programs. I think it could be up to 10 percent, it could be less than that.

Mr. SMITH OF MICHIGAN. So the evidence of the fraud that you detected represents what percentage?

Mr. MANGANO. If you look at the Federal Medicare program, it is $177 billion this year; 10 percent of that would be $17 billion. Medicaid Federal share is about $88 billion this year, and so we are talking about $8.8, billion if it is that high.

In empirical evidence, if you can draw a random sample of cases, you can generally find out where somebody has overbilled for something or misbilled for a service; but to prove fraud, you really have to go the full-scale investigation on every individual case. That is why it is so difficult to get a handle on how much fraud and abuse is out there. The abuse is a little easier to estimate than the fraud.

Mr. KUBIC. It might be helpful to note that one of the areas that we feel very comfortable with in terms of fraud and losses is in the financial institution fraud cases that the FBI also investigates. And in fiscal year 1993, there was a required reporting under that system. And in 1993, reported losses to the Bureau was about $12 billion.

So when we talk about losses of $17 billion or so diverted from the health care area you can see that that is really not that unusual when you consider the banking industry in the United States today with fairly stiff regulations, because of changes, reporting losses at $12 billion.

Mr. SMITH OF MICHIGAN. Have you investigated and evaluated the efforts of the States to shift their costs to Medicaid?

Mr. MANGANO. Just a few minutes ago we talked about the disproportionate share and taxation and donation area. That was probably the biggest shift of cost to the Federal Government from

the State share of the Medicaid cost. I do not think that anything else comes close to that.

Mr. SMITH OF MICHIGAN. Expand from that. How about other ways that the States are shifting the costs?

Mr. MANGANO. None come to mind in that area, but there are other areas that would be related to it. The one that is most prominent in my mind would be where States have programs for disability. The Federal Government, through its Supplemental Security Income Program, had something occurring over the last 5 years where more and more States were telling their perspective beneficiaries go over and apply for SSI first before applying for State benefits.

We found that the highest increases in the disability program were in the States that had that as a policy.

Mr. SMITH OF MICHIGAN. Mr. Kubic.

Mr. KUBIC. I cannot offer anything additional to the comments that have already been given. It is an area that we do not particularly look at in terms of the States shifting.

Mr. SMITH OF MICHIGAN. When I was in the State legislature we actually talked and evaluated the different ways of shifting some of that cost so maybe it is something you should be looking at if you have not been.

Mr. Anderson.

Mr. ANDERSON. Well, I, too, I am from a State attorney general's office so that is not part of our mandate.

Mr. SMITH OF MICHIGAN. I would not think so.

Thank you, Mr. Chairman.

Mr. SHAYS. Thank you all for testifying.

We will stand adjourned.

[Whereupon, at 2:30 p.m. the committee was adjourned.]

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ISBN 0-16-047506-6